

or net income as countable when determining whether the countable income is below the eligibility standard will result in State differences and families may be convinced to move to another State for coverage.

Response: Given the flexibility authorized by law, income tests would vary from State to State even if States were required to use the same method of arriving at countable income because the income standards to which the countable income is compared vary widely. Income standards (and often methodologies) for most Federally-assisted, means-tested programs vary from State to State. Research in this area indicates that individuals move to be with family or for employment and generally do not move for the purpose of receiving means-tested benefits. Income standards vary widely in Medicaid and there has been no evidence that this has resulted in families moving from State to State.

Comment: Two commenters specifically supported eliminating pre-existing conditions as a reason for denial and stated that such a policy is important to children with special needs. Two additional commenters stated that if States may not deny eligibility based on preexisting conditions, it may conflict with contracts between a separate child health program and a health plan or with premium assistance programs.

Response: Section 2102(b)(1)(B)(ii) of the Act prohibits the denial of coverage based on preexisting conditions and § 2103(f)(1)(A) prohibits eligibility restrictions based on a child's preexisting condition. We agree that this prohibition is very important in providing health care to low-income children with special needs and have included it at § 457.320(b)(2) of the regulations. States that have contracts with health plans which restrict eligibility based on preexisting conditions will have to renegotiate the contracts or otherwise ensure that the affected children are provided with care that meet the standards of title XXI.

One limited exception to this rule is permitted. Under § 2103(f)(1)(B) of Title XXI, if a State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance, the plan may permit the imposition of those preexisting conditions which are permitted under HIPAA. This permits the imposition of preexisting conditions consistent with the requirements of such plans when the State is providing premium assistance through SCHIP to subsidize child or family coverage under a group health plan or group

health insurance pursuant to § 2105(c)(3) of the statute.

Comment: We received one comment specifically supporting State latitude to establish eligibility based on State-established disability criteria. Another commenter recommended that we add a new § 457.320(b)(4) to specifically prohibit the use of eligibility standards that discriminate on the basis of diagnosis in accordance with section 2102(b)(1)(A).

Response: Section 2102(b)(1)(A) of the Act provides that an eligibility standard based on disability may not "restrict eligibility," although States may provide additional benefits to children with disabilities. This provision was included in the regulation at § 457.320(b)(3). Section 2102(b)(1)(A) of the Act also provides that no eligibility standard may discriminate on the basis of diagnosis. We have revised the regulation at § 457.320(b)(3), as suggested, to specifically prohibit discrimination on the basis of diagnosis. Therefore, a State may establish eligibility standards that are based on or related to the loss of certain functional abilities, whether physical or mental, if those standards result in children with disabilities qualifying for coverage. A State cannot, however, establish eligibility standards based on or related to a specific disease.

Comment: We received a significant number of comments urging HCFA to add specific residency requirements. Many of the commenters were concerned about children of migrant workers and homeless children. One commenter specifically urged HCFA to require States to set forth rules and procedures for resolving residency disputes. One recommended that the regulations explicitly provide that families involved in work of a transient nature be allowed to choose to establish residency in the State where they work or in one particular State. One commenter recommended that States be required to expedite enrollment of migrant children. One recommended that States be prohibited from the following: denying eligibility to a child in an institution on the grounds that a child did not establish residency in the State before entering the institution; denying or terminating eligibility because of temporary absence; or denying eligibility because residence was not maintained permanently or at a fixed address.

Response: Because Congress has specifically allowed States flexibility to establish standards, we do not establish general residency rules for States. However, we share the commenters' concern that certain children may be

unable to establish eligibility in any State because of disputes over residency and do not believe that allowing such a result would be consistent with the overall intent of title XXI and the requirement that SCHIP be administered in an effective and efficient manner. We have revised paragraph (a)(7) and added a new paragraph (d) to § 457.320 to specify residency rules in limited circumstances. In the case of migrant workers, when the child of a parent or caretaker who is involved in work of a transient nature, such that the child's physical location changes periodically from one State to another, the parent or caretaker may select either their home State or the State where they are currently working as the State of residence for the child. For example, if a migrant family moves temporarily from Florida to North Carolina and then returns to Florida during the course of a year as a result of the parents' transient employment, the parents can claim either Florida or North Carolina as the child's State of residence.

In other instances, where two or more States cannot resolve which is the State of residence, the State where a non-institutionalized child is physically located shall be deemed the State of residence. In cases of disputed residency involving an institutionalized child, the State of residence is the parent's or caretaker's State of residence at the time of placement. We believe that a child who is placed in an out-of-State institution should remain the responsibility of the State of residence at the time of placement. Similarly, in cases of disputed residency involving a child who is in State custody, the State of residence is the State which has the legal custody of the child. As indicated in the preamble to the proposed rule, under *Shapiro v. Thompson* (394 US 618), a State cannot impose a durational residency requirement. We have also added this prohibition to § 457.320(d).

We have not imposed further residency rules. However, we strongly recommend that States establish written inter-State agreements related to disputed residency. We note that the rules contained in § 457.320(d)(2) of this regulation apply only if the States involved cannot come to agreement with respect to a child's residency.

Comment: We solicited comments on our proposal that the eligibility standard relating to duration of eligibility not allow States to impose a maximum length durational requirement or any similar requirement. We received three comments in response, and all three recommended that the regulations make it clear that States are prohibited from

imposing time limits or lifetime caps on eligibility.

Response: Under section 2102(b)(1)(A) of the Act, States have considerable flexibility in setting the standards used to determine the eligibility of targeted low-income children, including those related to duration of eligibility. This enables States to establish the period of time for which a child determined eligible for the State's separate child health program can remain covered prior to requiring a redetermination or renewal of eligibility. At the same time, it is important to ensure that States can identify children enrolled in a separate child health program who become ineligible due to a change in circumstances. Therefore, we have retained the provision in proposed § 457.320(a)(10) and moved it to § 457.320(e)(2) to require that States redetermine a child's eligibility at least every 12 months. Note that termination of a child's eligibility at the end of the specified period (e.g. after a redetermination review) would constitute a "denial of eligibility" subject to the requirements of § 457.340(d) of this subpart and subpart K.

We agree that durational limits on eligibility are contrary to the intent of the program. We have added a new subsection § 457.320(e)(1) to include a prohibition against imposing time limits, including lifetime caps, on a child's eligibility for coverage. That is, a State cannot deny eligibility to a child because he or she has previously received benefits. The prohibition against lifetime caps or other time limits on coverage is consistent with Congressional intent to provide meaningful health care for children and will prevent unequal treatment of similarly-situated children simply because one child has been enrolled in the program longer than the other. It will also prevent the possibility of jeopardizing the health of low-income children by terminating or denying health care on the basis of circumstances unrelated to the child's needs. The prohibition against durational limits on eligibility does not prevent a State from limiting enrollment based on budget constraints, or capping overall program enrollment due to lack of funds. This is reflected in §§ 457.305(b) and 457.350(e). In addition, we have added a definition of "enrollment cap" in § 457.10 of subpart A.

Comment: One commenter specifically supported the concept of 12 months of continuous eligibility. Another recommended that the

regulations be more specific about the duration of eligibility. This commenter recommended an annual time period because health care should not be interrupted when income fluctuates, which the commenter believes happens frequently with the population being served. One commenter objected to requiring any interim screening process during an established 12-month continuous eligibility period.

Response: We see no basis to prohibit State review of eligibility on a less than annual basis. We do encourage States to establish an annual period of review and to adopt continuous eligibility rules to avoid interruptions in a child's health care because of minor fluctuations in income. Frequent reviews can be a barrier to enrollment and redetermination and can reinforce the "welfare stigma." In addition, research shows that many children lose coverage at the time of redetermination.

Between the scheduled reviews, regular, periodic screenings are not required. A child always has the right to file for and become eligible for Medicaid if family income changes, and the State is required to take action on the application, even if the child is covered by a separate child health program. If a child enrolled in a separate child health program does not file an application for Medicaid, the State is not required to screen the child for Medicaid eligibility until the next scheduled redetermination, regardless of changes in the child's circumstances (other than reaching age 19).

Comment: We received a significant number of comments on the discussion about pregnant teens included in the preamble, many of which expressed support for our position.

One commenter suggested that Illinois KidCare is a good model under which a pregnant teen is automatically transferred to the Moms and Babies Medicaid Program. Another recommended that HCFA clearly state an expectation that States provide information to teenage enrollees on the possible benefits of seeking Medicaid if they are pregnant, rather than simply urging them to do so. One commenter recommended that States be required to inform pregnant teens about the differences between their Medicaid and separate child health programs. This commenter also asserted that the benefits of keeping a trusted health care provider may override the benefits of broader coverage and lower out-of-pocket expenses and that States, therefore, should inform pregnant teenagers of the possibility that changing from one program to the other may require the teen also to change

doctors. Two commenters recommended that it be made clear that States providing information about Medicaid and the opportunity to apply for Medicaid cannot be held responsible for any individual who does not complete the Medicaid application process.

Several commenters objected to the recommendation that pregnant teens switch to Medicaid midyear. They argued that this unnecessarily disrupts continuity of care and has negative effects on pregnant teens. One of these commenters recommended that pregnant adolescents in their second or third trimester and adolescents with high-risk pregnancies be allowed to continue to see their treating provider through pregnancy and the 60-day postpartum period. Another commenter stated that the regulation related to monitoring pregnant teens and moving them to Medicaid in the middle of an eligibility period goes beyond statutory authority.

One commenter contended that all benchmark programs require pregnancy services and commented that establishing procedures for managed care contractors to notify the State of a teen's pregnancy would be cumbersome, expensive and a potential violation of the family's confidentiality.

Finally, one commenter was concerned that the discussion about pregnant teens not appear to foreclose separate child health programs from adopting pregnancy-related benefits for pregnant teens who are not eligible for Medicaid.

Response: We appreciate the comments, and we wish to clarify a number of points. In drawing attention to pregnant teens, it was not our intent to impose additional or unnecessary requirements on States nor to promote procedures that would disrupt the medical care of pregnant teens. Our intent was to ensure that pregnant teens are provided with sufficient, clear information about Medicaid to make an informed choice about staying in the separate child health program or applying for Medicaid. States are not required to monitor teens for pregnancy and cannot be held responsible for teens who choose not to apply for Medicaid. Managed care contractors in separate child health programs are not required to notify the State when a teen becomes pregnant. Finally, States may provide the same pregnancy-related services under separate child health programs that they do under Medicaid. We urge States to do this, but pregnancy-related services are not mandatory under separate child health programs. We also urge States to make every effort to rely

on the same plans and providers in their separate child health programs and Medicaid so that children who switch between programs because of changes in circumstances, including pregnancy, need not change providers.

While States are not under an obligation to ensure that teens enrolled in separate child health programs become enrolled in Medicaid if they become pregnant, we remind States that there are advantages to Medicaid for a pregnant teen even when the benefit package is the same. First, cost-sharing is prohibited for pregnancy-related services under Medicaid and premiums are prohibited if the woman's net family income is at or below 150 percent of the Federal poverty level. (Above that level premiums are limited to 10 percent of the amount by which the family income exceeds 150 percent of the Federal poverty level.) In addition, a child born to a woman who is eligible for and receiving Medicaid on the day the infant is born is deemed to have filed an application and been found eligible for Medicaid. That infant remains eligible for one year if residing with the mother, regardless of family circumstances. If the delivery is covered by a separate child health program because the mother does not apply for Medicaid, the infant might not be eligible for Medicaid instead of automatically eligible as would be the case had the delivery been covered by Medicaid.

Comment: Two commenters recommended that HCFA encourage States that have separate child health programs to provide newborn infants the same eligibility protections granted under Medicaid. Another recommended that HCFA allow pre-enrollment of newborns or automatic enrollment of newborns of pregnant teens enrolled in a separate child health program.

Response: The statute does not provide for automatic and continuous eligibility for infants under a separate child health program as it does under Medicaid. Moreover, it is also likely that due to higher income standards that most States apply in Medicaid, many infants born to teens enrolled in a separate child health program will be eligible for Medicaid and therefore not eligible for a separate child health program.

However, as discussed elsewhere in this preamble (in response to comments under both §§ 457.300 and 457.360), we have determined that States may use "presumptive eligibility" to enroll children in a separate child health program pending completion of the application process for Medicaid or the separate plan. We recognize the need of infants to have immediate coverage and

consider the automatic enrollment of newborns born to mothers covered by a separate child health program at the time of the delivery into the separate program as an example of such presumptive eligibility. Presumptive eligibility is time-limited, however, and States choosing to enroll these newborns must formally determine the infant's eligibility (including screening the infant for Medicaid eligibility) within the time frame set for completing the application process and determining eligibility.

As noted earlier, if the infant is ultimately found not to be eligible for Medicaid, costs of services provided during the period of presumptive eligibility may be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. Thus, States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

Alternatively, States can develop an administrative process to identify, prior to birth, an infant as a Medicaid-eligible individual as soon as he or she is born, as we understand some States have done. This would ensure that Medicaid coverage and services are immediately available to a Medicaid-eligible newborn child.

Comment: We received a large number of comments related to obtaining social security numbers (SSNs) during the application process. Many commenters specifically supported the prohibition against requiring the SSN in separate child health programs. Two requested clarification as to whether an SSN can be required on a joint SCHIP/Medicaid application. A few recommended that SSNs be required for applicants as long as there is a Medicaid screen and enroll requirement. One commenter did not advocate asking for an SSN, but commented that the policy for separate child health programs and Medicaid should be consistent because families prefer to give all information at one time and having a distinction between the requirements for the two programs hinders States' efforts to create a seamless program.

Some commenters indicated that the prohibition against requiring SSNs for a separate child health program while requiring it for Medicaid will cause referral, tracking and coordination problems; handicap enrollment in States using a joint application; make it

difficult to implement the screen and enroll provision; reinforce stereotypes; and prevent automatic income verification in States that have reduced the documentation requirements. Another added that this prohibition will impede efforts to identify children with access to State health benefits.

Finally, another commenter suggested that Medicaid medical support cooperation requirements include providing information about noncustodial parents and that this "section may be construed as excusing a Medicaid applicant from having to provide an SSN for all family members, including noncustodial parents absent from the home."

Response: The requirements and prohibitions related to the use of a social security number are statutory. The Privacy Act makes it unlawful for States to deny benefits to an individual based upon that individual's failure to disclose his or her social security number, unless such disclosure is required by Federal law or was part of a Federal, State or local system of records in operation before January 1, 1975. Section 1137(a)(1) of the Social Security Act requires States to condition eligibility for specific benefit programs, including Medicaid, upon an applicant (and only the applicant) furnishing his or her SSN. Because SCHIP is not one of the programs identified in section 1137 of the Act, and Title XXI does not require applicants to disclose their SSNs, States are prohibited under the Privacy Act from requiring applicants to do so.

Thus, only the SSN of the individual who is applying for Medicaid (including a Medicaid expansion program under title XXI) can and must be required as a condition of eligibility. Children applying for coverage under a separate child health program cannot be required to provide a SSN, and States cannot require other individuals not applying for coverage, including a parent, to provide a SSN as a condition of the child's eligibility for either a Medicaid expansion program or separate child health program.

We recognize that these statutory provisions can be difficult to reconcile in practice. Under the law, a joint Medicaid/SCHIP application must indicate clearly that the SSN is only needed for Medicaid and not for coverage under a separate child health program, but a family often will not know if their child is or is not Medicaid-eligible. A State may request the SSN for all applicant children as long as the State makes it clear that family members are not required to provide the SSN and that the child's eligibility under the

separate child health program will not be affected if the child's SSN is not provided. However, the State must also inform the family that Medicaid eligibility cannot be determined without the SSN and that the child cannot be enrolled in the separate child health program if the child otherwise meets the eligibility standards for Medicaid.

Comment: A significant number of commenters objected to the verification requirements pertaining to citizenship and alien status. Most of these commenters requested that subsection § 457.320(c) be deleted. A number of the commenters pointed out that we proposed to require that States follow INS rules which were not yet mandatory. Additionally, they argued that the requirement in § 457.320(b)(6) that States abide by all applicable Federal laws and regulations would be sufficient. Several commenters objected to the verification requirements for a number of reasons. A significant number of them commented that the procedures are too burdensome. One commenter felt that proof of citizenship might discourage some citizens who do not have birth certificates from applying. Another commented that requiring proof and verification of alien status would delay access to care for alien children who are otherwise eligible.

Response: Section 432 of the PRWORA requires verification of citizenship for applicants of all "Federal public benefits" as defined in section 401 of the PRWORA. However, proposed regulations published by the Department of Justice, which is responsible for enforcing the verification provision, provide that a State may accept self-declaration of citizenship provided that (1) the federal agency administering the program has promulgated a regulation which permits States to accept self-declaration of citizenship and (2) the State implements fair and nondiscriminatory procedures for ensuring the integrity of the program at issue with respect to the citizenship requirement.

Requiring documented proof of citizenship can be a time-consuming and difficult process for many applicants, and therefore could create a significant barrier to enrollment. It also can create a significant administrative burden for the State. Therefore, consistent with the statutory intent to promote access to and enrollment in separate child health programs and HCFA's policy to provide States with flexibility to simplify their application processes and eliminate barriers to enrollment wherever possible, we have modified § 457.320(c). The regulation

permits States to accept self-declaration of citizenship, provided that they have implemented effective, fair and nondiscriminatory procedures for ensuring the integrity of their application process with respect to self-declaration of citizenship.

For example, a State could implement a system to randomly check the documentation of some applicants and terminate the eligibility of any applicants found to have provided a false declaration. If the percentage of false declarations was found to be high, the State would need to take appropriate measures to remedy the problem—including, if necessary, requiring documentation to verify the citizenship of every applicant.

Comment: One commenter asked for clarification of the difference between "proof" and "verification."

Response: We have used "proof" to refer to documents provided by individuals. "Verification" is used to refer to the process of comparing the information in the "proof" to the INS records. An individual may be considered eligible based on "proof" while the information is being verified.

Comment: Several commenters urged that the regulations specifically prohibit requests for information about the citizenship or immigration status of non-applicants, including parents. One commenter indicated that States should be prohibited from verifying the status of any non-applicant when the information is voluntarily provided.

Response: Information about the citizenship or alien status of a non-applicant cannot be required as a condition of eligibility. States may request this information if it reasonably relates to a State eligibility standard and it is made clear that the provision of this information is optional and that refusing to provide the information will not affect the eligibility of applicants. We strongly urge States not to request this information nor to verify it if voluntarily provided, as this has been found to be a strong deterrent to alien parents filing applications on behalf of their citizen children.

Comment: One commenter recommended that HCFA issue, through letter or manual and web site, Medicaid guidance on the categories of immigrants eligible for Medicaid and that these regulations reference that guidance.

Response: Section 3210 of the State Medicaid Manual, which is available through links set for in HCFA's web site at www.hcfa.gov, discusses immigrant eligibility for Medicaid following passage of the Personal Responsibility and Work Opportunity Reconciliation

Act of 1996, although it does not reflect changes to immigrant eligibility contained in the Balanced Budget Act of 1997. We also have posted a fact sheet on the section of our web page addressing Medicaid and welfare reform. The fact sheet is entitled, "The Link between Medicaid Coverage and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996." Guidance to State Medicaid Directors dated December 8, 1997 discusses changes in immigrant eligibility for Medicaid under the Balanced Budget Act of 1997. Finally, guidance dated January 14, 1998 discusses immigrant eligibility for benefits under title XXI. This guidance (in the form of "Dear State Medicaid Director or Dear State Health Official letters") can be found at www.hcfa.gov.

We will consider issuing more detailed instructions pertaining to the eligibility of immigrants for Medicaid and separate child health programs and posting such guidance on our web site.

6. Application and Enrollment in a Separate Child Health Program (§ 457.340)

We proposed to require that the State afford every individual the opportunity to apply for child health assistance without delay. Section 2101(a) of the Act requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program. Because we have determined that proposed § 457.361 "Application for and enrollment in SCHIP," is closely related to this section, in this final rule we have incorporated the provisions of proposed § 457.361 into this section. We will respond to the comments concerning § 457.340 of the proposed rule here, and to those concerning § 457.361 of the proposed rule below, under § 457.361.

Comment: We received a number of comments on this section. Many commenters were concerned about the complexity of the application process, particularly when States have a separate child health program. Several commenters recommended that HCFA require States to certify that they have conducted a review of their Medicaid and Title XXI application and redetermination procedures and have eliminated any unnecessary procedural barriers that discourage eligible children from enrolling in and retaining coverage. If differences remain, States should be required to identify in their State plan the reasons for the differences and explain how they are consistent with the coordination goals of title XXI.

Other commenters added that families should not be forced to understand and navigate two sets of application, enrollment and redetermination procedures.

Several commenters focused on joint applications for Medicaid and separate child health programs. One commenter asked HCFA to highlight that States can use a joint application and a single agency. Another urged HCFA to require a joint application process or, at a minimum, to conduct rigorous oversight of the screen and enroll procedures. A third specifically indicated that HCFA should require States to have a single form for children who are applying for both programs, that it be limited to four pages, that States be required to accept mail-in applications and that States notify families when their application has been received. Yet another stated that the burden should rest with the State that chooses not to have a joint application to establish that its application procedures are effective. This commenter also recommended that HCFA require that the same verification procedures be used for both programs and that families not have to take any additional steps in order for their application to be processed by Medicaid.

One commenter felt that the regulations should define a joint application process rather than referring to joint forms. This commenter believes that applicants should be subject to the same requirements and procedures—including a single application, the same verification requirements, and common entry points—for both programs, and that nothing additional should be required for children to enroll in Medicaid under one of the categories identified in § 457.350(c)(2).

One commenter felt that States also should be required to certify that they have eliminated any unnecessary procedural barriers to children making a transition between regular Medicaid and a Title XXI-funded program when they lose eligibility for one program and become eligible for the other. Another thought it would be useful for HCFA to mention that flexibility regarding the eligibility determination process is not limited to contractors. Provider employees or outstationed workers at provider locations are also capable of making these determinations under a separate child health program.

Two commenters emphasized the importance of States applying any simplifications adopted in the application process for Medicaid or a separate state program to children whose families also are on Food Stamps or TANF. Some States which generally

allow families to apply for Medicaid on behalf of their children through a mail-in application reportedly do not accept mail-in applications from families who already happen to be receiving Food Stamps or TANF. In this commenter's view, such policies create inequities and impose unnecessary procedural barriers to Medicaid enrollment and HCFA should encourage States to review whether they have any such policies, and to eliminate them whenever possible.

Other commenters recommended that HCFA place emphasis not only on helping families to apply for coverage, but also on helping them to remain enrolled in coverage. They felt that the simplification strategies listed by HCFA should also include States' adopting the same redetermination period in Medicaid and separate child health programs, and reducing verification requirements for redeterminations as well as for the initial application.

Response: States are required to establish a program that is "effective and efficient" and a process that allows every individual to apply for child health assistance without delay. Mail-in, joint program application forms, common entry points and applicable procedures, single agency oversight and administration, and simplified and consistent program rules and documentation requirements are several ways that States can facilitate families' ability to apply for the appropriate health coverage program as expeditiously as possible. These procedures can also simplify administration for States. While we are not requiring that States use any specific mechanism, States that do not take steps to streamline, align, and coordinate their enrollment process will have a more difficult time ensuring that children can apply for health insurance coverage without delay and that their application is assessed in an effective and efficient manner.

We encourage, but do not require, States to use a joint application for their separate child health program and Medicaid programs and to simplify the application as much as possible. We agree with the comment that States should construct a joint application process, rather than just a joint application. States that have adopted the same or similar rules relating to application interviews, verification and managed care enrollment have an easier time coordinating the enrollment process. We note that most States with separate child health programs report they use a joint child health application and that joint applications do not

necessarily need to cover all possible Medicaid eligibility groups.

Section 2102(c) requires coordination of the administration of SCHIP with other public and private health insurance programs, and we also will be monitoring States' coordination of enrollment in their separate child health program and Medicaid programs, including children's transitions from one program to the other. HCFA will pay particular attention to outcomes in States that lack many of the elements of a streamlined and coordinated system. When appropriate, such monitoring will include requests for States to identify the number of children found potentially eligible for Medicaid, the percentage of those children who have been determined eligible for and enrolled in Medicaid, and the percent determined eligible for and enrolled in the separate child health program. These data will help States and HCFA determine whether the State has developed an effective method to coordinate enrollment and ensure that children are enrolled in the appropriate program.

While States have and will continue to have the flexibility to design their own unique application and enrollment systems, States will be held accountable to ensure that children are afforded the opportunity to apply for the appropriate program in a timely and efficient manner. We believe that most States have developed coordinated enrollment procedures and are continuing to improve their systems to promote enrollment of eligible children, and we will continue to work with the States in developing effective systems.

It is also true, as a few commenters pointed out, that eligibility determination for a separate child health program may be performed by a wide range of entities, as determined by the State. For example, State Medicaid agencies, health care plans and providers, and outstationed State or local eligibility workers also may determine eligibility.

Finally, we agree with the last two points made by the commenters. First, we agree that States' simplifying both initial application and redetermination processes is critical. Second, we also agree that States can reduce barriers to accessing health care for all families by applying any simplifications adopted in the application process for Medicaid and the separate child health program to the application process for children whose families also happen to be receiving, or applying for, Food Stamps or TANF benefits, and we encourage States to do so.

Comment: Several commenters requested that States be given flexibility to use the application for a program other than Medicaid or SCHIP.

Response: States may use a joint application with other programs. Proposed § 457.340(b) was confusing and may have implied that States do not retain discretion over whether or not to combine the applications of different programs. Because we do not want to preclude States from including programs other than Medicaid and SCHIP in a joint application and because a regulation is not needed to allow States to adopt a joint application, we have eliminated § 457.340(b). This in no way implies that States are prohibited from using joint applications. In fact, we continue to strongly encourage States to consider how joint applications might promote coverage of eligible children.

For example, the application for Medicaid and/or a separate child health program may be combined with an application for child care assistance or WIC. Joint applications can be an effective outreach and enrollment tool because they can help States reach families that are being served by other programs. States that use a joint application, however, must develop a process that allows every individual to apply for child health assistance without delay. If the application for the separate child health program and/or Medicaid is combined with an application for other services or benefits and sufficient information is provided to make a determination of eligibility for child health coverage, that determination must not be held up because of information (or action) which is needed for the other program. Joint program applications, while an effective tool, must not result in delays that would be contrary to the intent of the statute and this section.

Comment: One organization commented that the regulations should clarify that underlying the provision at proposed § 457.340(a) regarding the opportunity to apply without delay are title VI of the Civil Rights Act and the Americans with Disabilities Act.

Response: Underlying the provision that individuals be able to apply without delay is section 2101(a) of the Act, which requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program.

Of course, this opportunity must be available to all children, regardless of their race, sex, ethnicity, national origin or disability status. Thus, the civil rights

laws must be adhered to in implementing this requirement, but are not the only statutory authority for this provision.

Comment: One commenter expressed strong support for the requirement that every individual be afforded the right to apply. The commenter asserted that adolescents not living with their parents should be allowed to file their own applications and recommended that HCFA, through the preamble, encourage States to adopt policies that facilitate the filing of applications by adolescents themselves.

Response: As required by this section, States must afford every individual, including adolescents, the opportunity to apply for child health assistance without delay. We encourage States to consider how they might best ensure that adolescents, including those who are not living with their parents or caretakers, can apply for SCHIP. States can also allow adolescents to sign their own applications; but this is a matter of State law and we cannot require States to permit minors to do so.

Comment: One commenter stated that the regulations should address methods for allowing families to report changes in circumstances in an efficient, family-friendly manner, such as not requiring the family to complete a new application when circumstances change.

Response: Section 2101(a) of the Act requires that child health assistance be provided in an effective and efficient manner. A reporting system which requires that a child reapply every time there is a change in family circumstances affecting eligibility would not constitute effective and efficient administration. The precise manner in which an individual reports changes is subject to State discretion, as is the form used for periodic redetermination. States should develop methods of reporting changes that pose as few barriers to uninterrupted eligibility as possible and do not require families to resubmit information that has not changed. States that have opted to provide continuous eligibility generally do not require reporting of any changes in circumstances except at regularly scheduled redeterminations.

7. Eligibility Screening and Facilitating Medicaid Enrollment (§ 457.350)

Sections 2102(b)(3)(A) and (B) of the Act require that a State plan include a description of screening procedures used, at intake and at any redetermination, to ensure that only children who meet the definition of a targeted low-income child receive child health assistance under the plan, and that all children who are eligible for

Medicaid are enrolled in that program. In accordance with the statutory provisions, we proposed at § 457.350(a) that a State plan must include a description of these screening procedures.

More specifically, section 2110(b)(1)(C) of the Act provides that children who would be eligible, if they applied, for Medicaid are not eligible for coverage under a separate child health program. Section 2102(b)(3)(B) provides that States have a responsibility to actually enroll children who have applied for a separate child health program in Medicaid if they are Medicaid-eligible.

As stated in previous guidance, referrals to Medicaid do not satisfy this "screen and enroll" requirement. In accordance with the statute, we proposed to require States to use screening procedures that identify any child who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(l) of the Act. However, since States are not mandated to cover children below the age of 19 who were born before October 1, 1983 under the poverty-level-related Medicaid groups, we also proposed at § 457.350(c) to require, at a minimum, that a State use screening procedures that identify any child who is ineligible for Medicaid under the poverty level related groups solely because of age but is potentially eligible under the highest categorical income standard used under the State's title XIX State plan for children under age 19 born before October 1, 1983. In almost all circumstances, we expected that the highest categorical income standard used for such older children will be the standard used for the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I) of the Act. These children are sometimes referred to as "Ribicoff children." (See § 435.222.) Mandatory coverage of the older children in poverty-level related groups is being phased in and by October 1, 2002, all children under age 19 will be included in the poverty-level-related groups in all States.

In the preamble of the proposed rule, we encouraged States to identify any pregnant child who is eligible for Medicaid as a poverty-level pregnant woman described in section 1902(1)(1)(A) of the Act even though she is not eligible for Medicaid as a child. We noted that Medicaid coverage, cost-sharing rules and eligibility rules pertaining to infants may be more advantageous to a pregnant teen than coverage under a separate child health program.

We proposed at § 457.350(d) that to identify children who are potentially eligible for Medicaid, States must either initially apply a gross income test and then use an adjusted income test for applicants whose State-defined income exceeds the initial test, or use only the adjusted income test for all applicants. We set forth the initial gross income test and the adjusted income test at proposed § 457.350(d)(1) and (2) respectively.

As indicated in section 2102(b)(3)(B) of the Act, Congress intended that children eligible for Medicaid be enrolled in the Medicaid program. We proposed at § 457.350(e)(1) that, for a child found potentially eligible for Medicaid, the State must not enroll the child in the separate child health program unless a Medicaid application for that child is completed and subsequently denied.

At § 457.350(e)(2) we proposed that the State must determine or redetermine the eligibility of such a child for the separate child health program if (1) an application for Medicaid has been completed and the child is found ineligible for Medicaid or (2) the child's circumstances change and another screen shows the child is ineligible for Medicaid. Finally, at § 457.350(e)(3), we proposed that if a child is found through a State screening process to be potentially eligible for Medicaid but fails to complete the Medicaid application process for any reason, the child cannot be enrolled in a separate child health program. Enrollment in a separate child health program for such a child can occur only after the Medicaid agency determines that a child who has been screened and found likely to be eligible for Medicaid is not in fact eligible for Medicaid under other eligibility categories.

We also proposed to require at § 457.350(f) (§ 457.350(g) in this final regulation) that States choosing not to screen for Medicaid eligibility under all possible groups provide certain written information to all families of children who, through the screening process, appear unlikely to be found eligible for Medicaid. We proposed that the following information must be provided to the person applying for the child: (1) a statement that, based on a limited review, the child does not appear to be eligible for Medicaid but that a final determination of Medicaid eligibility can only be made based on a review of a full Medicaid application; (2) information about Medicaid benefits (if such information has not already been provided); and (3) information about how and where to apply for Medicaid.

We have incorporated the provisions of proposed § 457.360, "Facilitating Medicaid enrollment," into § 457.350 because the requirements of both sections relate to the steps which the State or contractor responsible for determining eligibility under a separate child health program must take to comply with the "screen and enroll" requirements of Title XXI. In § 457.350(a), we therefore have added a requirement that the State plan include a description of the procedures the State will use to ensure that enrollment in Medicaid is facilitated for children screened potentially eligible for Medicaid and who are then determined by the State Medicaid agency to be eligible for Medicaid.

We will respond to the comments on the proposed § 457.360 in our discussion of § 457.360 rather than in our discussion of this section. Also, note that the obligations of the Medicaid agency in meeting the screen and enroll requirements are set forth in a new § 431.636, which is discussed further in subpart M of this preamble, "Expanded coverage of children under Medicaid and Medicaid coordination."

We noted in the preamble that there is great concern among a number of States and others that children will go without health care because of these screen and enroll policies. The concern centers around the perceived stigma of Medicaid. Some families may refuse to apply for Medicaid because they associate it with "welfare." Some families may not complete the Medicaid application process because it may be more complicated than the application process for a separate child health program, may require more documentation, or may otherwise be seen as more invasive into personal lives. We solicited comments on the extent of these problems and possible solutions. We received many comments concerning the screen and enroll requirements. These comments are addressed below.

Comment: One commenter indicated that the term "found eligible" should be used consistently. The regulations should not say that a child is "found eligible" for Medicaid through the screening process and then indicate that when the Medicaid application is processed the child is not "found eligible" for Medicaid.

Response: We agree with the comment. A child who has been found through the screening process to be potentially eligible for Medicaid has not been determined eligible for Medicaid. We have revised the regulations to use the terms consistently. As revised, the term "found eligible" is only used when

a final action has been taken on a Medicaid application and the child has been enrolled in Medicaid. The term "potentially eligible" is used when a screening indicates that a child appears to be eligible for Medicaid and therefore may not be enrolled in a separate child health program until action is taken on his or her Medicaid application.

Comment: One commenter suggested that the regulations require that States provide comprehensive training to eligibility determination workers (and other workers as appropriate) in both Medicaid and a separate child health program to ensure that all potentially eligible applicants are afforded the right to apply and that no eligible children are terminated inadvertently or inappropriately.

Response: One aspect of minimizing barriers and assuring appropriate action with respect to applications is providing adequate training to eligibility workers. States will need to ensure that such training has been, and continues to be, provided, as appropriate.

Comment: A significant number of commenters supported the policy that a child could be "found ineligible" for Medicaid through either a regular Medicaid application or through a screening rather than requiring that an actual Medicaid application be filed and a formal determination be made that the child is Medicaid-ineligible.

Response: The clear intent of title XXI is to provide benefits only to children who do not meet Medicaid eligibility requirements in effect before title XXI was enacted. This policy ensures that SCHIP funds will be used to cover only newly eligible children and not supplant funds already available through Medicaid to cover eligible children at the applicable Medicaid FMAP. This policy also ensures that children who are eligible for Medicaid benefits and cost-sharing protections receive the benefits and protections to which they are entitled. At the same time, Congress intended for children to be able to apply for, and obtain, health care insurance as quickly as possible, without lengthy delay. Requiring a formal denial by the State Medicaid agency in all cases would not promote the intent of the law. Permitting children who are found unlikely to be eligible for Medicaid through a screening process to proceed with their application under a separate child health program without a formal Medicaid determination be made, best balances these two goals.

Comment: Some commenters were concerned that States would make the Medicaid application process difficult and unfriendly while making the

application for a separate child health program simple so that families would choose to apply for the separate program but not Medicaid, and that the State would get the enhanced Federal match. One commenter particularly supported the policy that refusal to apply for Medicaid affects eligibility for a separate child health program. A number of other commenters objected to the policy of denying eligibility for a separate program when a child is found potentially eligible for Medicaid but the family makes an informed choice not to apply for Medicaid or chooses not to complete the Medicaid application process. One commenter argued that this policy goes beyond statutory authority. Most of those objecting to the policy expressed concern that it would result in children going without health coverage at all.

Response: How well the screening process works depends in large part on State Medicaid application rules and procedures. States have broad discretion under federal law to simplify and streamline their enrollment processes. We encourage States to simplify the Medicaid application process and to make the division between separate child health programs and Medicaid appear seamless, and many States have done so.

While we recognize that some families may decide to go without insurance rather than apply for Medicaid, we believe that it would be contrary to the statutory purposes to permit States to enroll children in a separate child health program who have been found potentially eligible for Medicaid through a screening process. As many States have demonstrated, States have the flexibility to address most, if not all, of the reasons why families might prefer not to apply for Medicaid. If families are reluctant to apply for Medicaid, the State may need to reexamine the Medicaid application and redetermination process, as well as its outreach and marketing strategies, to assess how barriers to participation can be eliminated. For example, States have shown that families are more likely to complete the Medicaid application process if face-to-face interviews are eliminated, resource tests for children are dropped and documentation requirements are reduced. If a joint application process and a single program name are used, the procedures can be made seamless and the difference between separate child health programs and Medicaid made almost invisible to the family. States are continuing to experiment with different ways to promote seamless enrollment and coverage systems.

HCFA will be focusing considerable attention over the coming months on ways to help States develop seamless, family-friendly application and eligibility determination systems and to promote best practices across States. These practices will not only help States meet the screen and enroll requirements, but also will help States identify and enroll the millions of uninsured children who are eligible for, but not enrolled in, Medicaid.

Comment: Many of those commenting on the screening requirements were concerned that not all children who are eligible for Medicaid will be identified. A number of commenters disagreed with the policy that the screening process only needs to screen for eligibility under the children's poverty level groups described in 1902(l). Quite a few were concerned that children with special needs who might qualify for Medicaid under another eligibility group will end up enrolled in a separate child health program that may provide less coverage than Medicaid. Some urged HCFA to require that States ask whether a child is disabled or has special needs. Others disagreed with the statement in the preamble that requiring States to screen for eligibility under all possible groups would place an unreasonable administrative burden on States. These commenters pointed out that States have considerable flexibility to simplify eligibility under Medicaid, particularly under section 1931.

One commenter noted that screening and determining eligibility are not the same. This commenter suggested that it is quite feasible to devise a simple, short list of questions to screen for eligibility in non-poverty related groups, and that the regulations should require that States screen considering the most liberal income eligibility standard for the child given the child's age, disability and the family's prior eligibility for § 1931. One commenter suggested that States be required to screen for eligibility for children under sections 1931 and 4913 of the Balanced Budget Act of 1997. Four others suggested that the regulations should require States to screen considering the highest effective income threshold, taking income disregards into account.

One commenter expressed concern about the extent to which income exclusions and disregards must be applied in the screening process. This commenter suggested that the screening should include only the standard deductions applicable to all poverty-level Medicaid eligibility groups. Another commenter stated that requiring independent entities to be knowledgeable about income exclusions under other Federal statutes,

particularly those which are not likely to be encountered, is contrary to simplification.

Finally, one commenter was concerned that a pregnant teen who could be eligible for Medicaid as a pregnant woman might be found ineligible for both a separate child health program and Medicaid if the screening process did not include a method of identifying pregnant teens.

Response: We have tried to balance the statutory screen and enroll requirements with the requirement that child health benefits be provided in an "effective and efficient manner," taking into consideration the fact that screening may be done by entities that may not be familiar with the intricacies of Medicaid eligibility. For this reason, we have not required a full Medicaid application or a formal decision on such an application before a child can be eligible for a separate child health program.

We have, however, reevaluated our position on screening for eligibility under section 1931 of the Act in light of the fact that in some States the highest eligibility threshold for non-disabled children is applied through the § 1931 eligibility group. We also recognize that some States expanded Medicaid eligibility through the authority of section 1115 of the Act, resulting in a higher eligibility threshold for some children. We have revised § 457.350(b) (proposed § 457.350(c)) to require that a State that has used the flexibility provided under § 1931 to expand eligibility must screen for eligibility under one of the poverty level groups described in section 1902(l), section 1931 of the Act, or a Medicaid demonstration project under section 1115 of the Act, whichever standard generally results in a higher income eligibility level.

States that have expanded eligibility under section 1931 beyond the poverty level category generally have adopted similar income eligibility rules; at a minimum, the section 1931 income methodologies are not likely to be significantly more complicated than the poverty level rules. Further, States need not screen families under both section 1931 and section 1902(l). Rather, they must screen under whichever methodology generally results in a higher income eligibility level for the age group of the child applying for assistance.

Because we are requiring States to screen under whichever methodology generally results in a higher income eligibility level, States do not have to apply every income and resource disregard used under its State plan.

Disregards that apply only in very limited circumstances need not be routinely used in the screening process. For example, many families applying for coverage under section 1931 would be expected to have earned income, so earned-income disregards must be applied in the screening process. However, few applicant families would be expected to have income-producing property. Thus, a State that disregards such income under section 1931 would not have to apply this disregard in the screening process.

We had included proposed § 457.350(c)(2) in the proposed rule to ensure that the children eligible for Medicaid under section 1902(a)(10)(A)(ii)(I) (the "Ribicoff children") would not be missed in the screening process. However, most of these children will be identified under the revised § 457.350(b). Therefore, cognizant of the need to keep the screening process as simple as possible, we have removed proposed § 457.350(c)(2) from the final regulation.

We share the commenters' concern about children with disabilities being left out of the screening process and strongly encourage States to screen for children who might be eligible for Medicaid on the basis of disability. Questions about a child's potential disability may be included on the separate child health or joint SCHIP/Medicaid application for follow-up. We require States to ensure that parents are provided with information about all Medicaid eligibility categories and coverage, are encouraged to apply for Medicaid under other eligibility categories and are offered assistance in applying for Medicaid. However, we do not agree with the comment that a child should be denied coverage under a separate child health program unless a full Medicaid disability determination has been made. The definition of disability for Medicaid purposes is not easily understood by people unfamiliar with Medicaid eligibility rules, and screening for eligibility based on disability could be very time-consuming. We note that States have 90 days, rather than 45, to determine Medicaid eligibility when disability is involved. Moreover, particularly in light of recent State Medicaid expansions, most children who would be eligible for Medicaid on the basis of disability will also meet the eligibility requirements as a poverty level child.

We also do not specifically require States to screen for eligibility under section 4913 of the BBA. The State is responsible for ensuring that disabled children who lost SSI because of the change in the definition of childhood

disability ("section 4913 children") are aware of their right to Medicaid benefits. States must identify and provide coverage for section 4913 children, but it is highly unlikely that a child who would be eligible as a section 4913 child would not be identified in the screening process as potentially Medicaid eligible on the basis of his/her income alone. In any event, Medicaid confidentiality rules do not allow States to provide lists of section 4913 children to entities that determine eligibility for a separate child health program but that do not also determine Medicaid eligibility.

Comment: One commenter pointed out that a screening based on income alone would be insufficient in a State that continues to apply a resource test to children under Medicaid. They recommended that § 457.350 be revised to clarify that, in such situations, States must evaluate whether children meet both income and resource tests for Medicaid eligibility.

Response: We agree that, in States that continue to apply a resource test to children under Medicaid, when an income screen indicates that a child is potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility under the applicable Medicaid resource test. A resource screen limits those cases in which a child is found potentially eligible for Medicaid based on an income test, but is then reviewed under Medicaid rules and found ineligible based on resources (and is then sent back to the separate child health program for another eligibility review). We have added a new paragraph (d) to § 457.350 to include this requirement. If a State continues to apply a resource test for children under the eligibility groups described in § 457.350(b) (§ 457.350(c) in the proposed rule) and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing the family's countable resources to the appropriate Medicaid resource standard. In conducting the screening, the State must apply Medicaid policies related to resource requirements, including policies related to resource exclusions and disregards and policies related to resources for particular Medicaid eligibility groups. However, in an effort to balance the statutory mandate that children eligible for Medicaid not be enrolled in a separate child health program with the need to keep the screening process as simple as possible, States need not take into account disregards that apply only in very limited circumstances in the screening process. Any resource

exclusions and disregards which the State does not plan to use in the screening process must be identified in the State plan.

Since most States no longer apply a resource test to children, this added screening requirement will not affect most States. State experience indicates that children who are income eligible seldom have resources in excess of the resource standard previously used, with the possible exception of a car that is usually needed for transportation to and from work. States have found that requiring information about resources that are highly unlikely to make a child ineligible, or that rarely provide a family with a greater ability to purchase health coverage, is an unnecessary administrative burden, a barrier to eligibility, and helps to reinforce the "welfare stigma." HCFA encourages the few States with resource requirements for children to eliminate or otherwise simplify any remaining resource tests under both Medicaid and separate child health programs. However, any State that retains a resource test for Medicaid must screen all applicants who appear income-eligible for Medicaid for eligibility under the applicable resource test.

Comment: One commenter indicated that screening is particularly difficult when an employer-sponsored model is used for SCHIP. This commenter suggested that States be given the option to accept a lower Federal match, for example, the Medicaid match, in lieu of meeting the Medicaid screen and enroll requirements.

Response: We do not have the statutory authority to provide a lower match in lieu of meeting the Medicaid screen and enroll requirements. Furthermore, because eligibility determinations are distinct from determinations about the kind of coverage an eligible child will receive, there does not seem to be any reason why the screen and enroll requirements would present any particular problems for States with premium assistance programs. States are required to screen all children applying for coverage under a separate child health program.

Comment: We received a significant number of comments concerning the requirement that certain information about Medicaid be provided to families if a State uses a screening procedure other than a full determination of Medicaid eligibility. Many commented that this requirement is administratively burdensome, a waste of administrative resources, exceeds statutory authority, and is contrary to the purpose and goal of the separate child health program option provided by Congress. Some

commenters believed that this requirement would mean that a full Medicaid determination needs to be made in every case. Others were concerned that it would be confusing to families whose children were found eligible for a separate child health program, would slow down the eligibility determination process, and would create a barrier to access in situations where the family did not want Medicaid. Several commenters stated that there is no evidence that Medicaid-eligible children are being missed in the screening process and that to the contrary, State-based evidence suggests that many more such children are being found than anticipated.

Other commenters did not think that the notice requirements went far enough and they urged HCFA to require that the information provided describe disability-based, medically-needy and § 1925 transitional Medicaid eligibility. One commenter recommended that proposed § 457.350(f)(1) be revised to read “based on limited review, we could not tell if your child is eligible for Medicaid.” Another recommended adding “and orally in a manner that is literacy and language appropriate” to the lead-in to the required list of notifications. One commenter recommended that the final rule include an example of notice language to be sent to children who are determined unlikely to be Medicaid-eligible as a result of a limited screening process. Several others questioned whether the cost of providing the information about Medicaid would be an SCHIP administrative cost subject to the 10 percent cap on administrative expenses.

Response: Providing information about Medicaid will not necessarily create a barrier to enrollment. Families are entitled to have complete information on which to base a decision about applying for coverage. We are pleased that reports from many States indicate that many Medicaid-eligible children are being found through the screening process. However, the results across all States are not uniform and there is no way to know how many other Medicaid-eligible children are not being identified. Because all families are entitled to have information on their child’s eligibility for coverage, we are retaining this provision with clarification.

We agree that families need to understand that no formal determination of the child’s Medicaid eligibility has been made, nor has the child been screened under all Medicaid eligibility categories. We note that a Medicaid determination does not need to be made in every case, but rather only

for those children screened as potentially eligible for Medicaid using the joint application, and that a Medicaid eligibility determination can only be issued by the State agency designated to make the determination. In the instance where the same agency that makes the Medicaid determination of eligibility also determines eligibility for the separate child health program, a determination of Medicaid eligibility must be issued, in addition to the notice required at § 457.350(e).

We have clarified the language of proposed § 457.350(f) at § 457.350(g)(1) of this final rule to provide that the State must inform the family, in writing, that based on a limited review, the child does not appear to be eligible for Medicaid, but that Medicaid eligibility can only be determined from a full review of a Medicaid application under all Medicaid eligibility groups. We have not included actual or proposed notice language in the final rule. Due to the differences in Medicaid programs, the language necessarily will vary from State to State. However, we are working to identify good notice language and best practices and will disseminate this material to States.

We expect that the information will be comprehensive and include information about Medicaid eligibility based on disability, pregnancy, excessive medical expenses, or unemployment of the family wage earner. We also expect that this information will be provided in a simple and straightforward manner that can be understood by the average applicant and that meets all applicable civil rights requirements, including the Americans with Disabilities Act (ADA). The information can be provided along with other information conveyed to SCHIP applicants or it can be a separate notice. The cost of providing information about Medicaid eligibility need not be a SCHIP administrative expense subject to the 10 percent cap. A State may choose to charge the cost of providing information about Medicaid as an administrative expense under title XIX.

Comment: A few commenters indicated that the regulations should make it clear that a child can be enrolled in a separate child health program while undertaking the full Medicaid application process. Other commenters recommended enrolling a child in a separate child health program for 45 days to allow processing of the Medicaid application.

Response: As discussed above, at its option, a State may provisionally enroll or retain current enrollment of a child who has been found potentially eligible

for Medicaid in a separate child health program, for a limited period of time, as specified by the State, pending a final eligibility decision. However, the child cannot be “eligible” for the separate program unless a Medicaid application is completed and a determination made that the child is not eligible for Medicaid.

As noted above, we have revised our policy based on the recent enactment of BIPA to permit health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and § 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with § 435.1101 to no longer be constrained by the 10 percent cap.

Comment: We received several comments urging HCFA to emphasize opportunities for simplifying the screen and enroll process and making the process “family-friendly.” Among the suggestions were: using a joint application or a single State agency; avoiding confusing options for families to opt in or out of Medicaid; eliminating age-based rules; adopting the same verification requirements as Medicaid; adopting the same income and resource methodologies as Medicaid; eliminating documentation requirements in Medicaid that are not required by the separate child health program; and requiring that any simplifications in the application process that States adopt for Medicaid or a separate child health program not be denied to children whose families also happen to be TANF or Food Stamp applicants or recipients.

Response: The suggested simplifications are ways in which confusing options and complex procedures can be eliminated and the screen and enroll process be made “family-friendly.” We encourage States to adopt these simplifications. As States experiment with new ways to coordinate their child health coverage programs, they are finding that alignment of program rules and procedures can greatly simplify the task of coordinating enrollment. As for children who are also applying for, or are receiving, Food Stamps or TANF, we emphasize that, while States may use joint child health, Medicaid, Food Stamp and TANF applications, they cannot condition Medicaid eligibility on Food Stamp or TANF requirements that

do not apply to Medicaid. For example, if a State Medicaid program does not require a face-to-face interview to determine a child's eligibility for Medicaid, a child applying for Medicaid and Food Stamps on a joint application cannot be denied Medicaid simply because the child's family does not comply with the Food Stamp interview requirement. Similarly, States cannot condition eligibility for a separate child health program on Food Stamp or TANF requirements that do not apply to that program.

Comment: Many of those who commented on the screen and enroll process were concerned generally about families "falling through the cracks" because of the back and forth between separate child health programs and Medicaid or going without any health care for a period of time because of the process requirements. One commenter was particularly concerned about children leaving State custody from foster care or the juvenile justice system, who are at great risk of failing to apply for health coverage after they leave State custody. A significant number suggested that the regulations provide that a State cannot require a child to reapply for a separate child health program if the child is screened potentially eligible for Medicaid, but later determined ineligible for Medicaid. Most suggested that the separate child health program application should be suspended or provisionally denied when a child is found to be potentially eligible for Medicaid, pending a final Medicaid eligibility determination.

Other commenters found the distinction between joint and separate applications confusing with respect to the screening requirements. The commenters requested clarification as to whether the procedures for use of joint applications also apply to separate child health programs.

Response: There are many policies and procedures that States with separate child health programs can adopt to ensure that children do not "fall through the cracks." When a child is identified through screening as potentially eligible for Medicaid, States may suspend, deny or provisionally deny the separate child health application. Alternatively, if the State has established a presumptive eligibility process for a separate child health program, the State may enroll an applicant in the separate child health program pending the formal determination of Medicaid eligibility; we have added a new section § 457.355 to reflect this option. It should also be noted that we have revised our policy to allow health coverage expenditures for

children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

We also have clarified the regulations at § 457.350(f)(5) (§ 457.350(e)(2) in the proposed regulations) to require that, if a child screened potentially eligible for Medicaid is ultimately determined not to be eligible for Medicaid, once the State agency or contractor that determines eligibility for the separate child health program has knowledge of the Medicaid determination, the child's original application for the separate child health program must be reopened or reactivated and his/her eligibility under the separate child health program determined without a new application. We believe that most States currently follow this procedure to ensure that the screening process does not improperly deny coverage under the separate child health program.

As discussed below, we have also added a rule directed to the Medicaid agency that requires that agency to promptly inform the SCHIP agency or contractor when a child who has been screened as potentially eligible for Medicaid is found ineligible for Medicaid (see section 431.636 of this chapter).

We have clarified § 457.350(f)(1) (§ 457.350(e)(1) in the proposed rules) to indicate that a State may suspend, provisionally deny or deny the application of a child screened potentially eligible for Medicaid. (Note that to provisionally deny an application is the same as finding the child provisionally ineligible for the separate child health program.) Putting the application into suspense for a reasonable period of time before taking action on it would preserve the child's initial application date and ensure follow-up on the part of the State agency or contractor after the specified time period had elapsed or the agency or contractor learned that the child has been determined ineligible for Medicaid, whichever is sooner. If a State provisionally denies the application and the child is subsequently determined ineligible for Medicaid, the child's initial application would be reactivated

as soon as the State agency or contractor that determines eligibility for the separate child health program learns of the denial of Medicaid eligibility. In either case, the family would not need to provide any additional information (unless there has been a change in circumstances that could affect eligibility).

In most circumstances, no further action on the part of the family will be necessary to reactivate or reopen the application for the separate child health program following a denial of Medicaid eligibility. For example, in States in which the State Medicaid agency also determines eligibility for the separate child health program, no further action on the part of the family will be required. Similarly, States that use a joint application and that closely coordinate the eligibility determination process (for example, through electronic transfers or by co-locating eligibility workers) can ensure that Medicaid determinations for children identified as potentially Medicaid-eligible can be made quickly and that the decision (and underlying information) can also be conveyed quickly back to the workers responsible for determining eligibility for the separate program.

We agree that the screening requirements are the same whether a joint application or separate applications are used, although the procedures States will need to adopt to meet these requirements will vary depending on whether a joint application is used. Therefore, we have deleted proposed § 457.350(b) to eliminate confusion. All States, including those that use a joint application, are required to meet the screening requirements in § 457.350.

We have added a new subparagraph § 457.350(f) to clarify the State's responsibilities for ensuring that the Medicaid application process for a child screened potentially eligible for Medicaid is initiated and, if eligible, that the child is enrolled in Medicaid, as required by section 2102(b)(3)(B) of the Act.

In general, in States that use a joint application, the State agency or contractor that conducts the screening shall promptly transmit the application and all relevant documentation to the appropriate Medicaid office or Medicaid staff to make the Medicaid eligibility determination, in accordance with the requirements of § 431.636, a new provision which sets forth the Medicaid agency's responsibilities with respect to the screen and enroll requirements of title XXI. Because the agency administering the separate child health program may not be the agency

authorized to make Medicaid determinations in the State, it is at the point when the joint application form is transmitted to the Medicaid office from the separate program that it becomes a Medicaid application. We have added the definition of "joint application" at § 457.301 to clarify this point and to facilitate the processing of joint applications. Specifically, we define a joint application as a form used to apply for a separate child health program that, when transmitted to the Medicaid agency following a screening that shows the child is potentially eligible for Medicaid, may also be used to apply for Medicaid. We encourage States that use a separate application for a separate child health program to design their applications so that families can easily waive confidentiality under SCHIP to allow the agency or contractor that conducts the screening to transfer information to the Medicaid agency when a child has been found potentially eligible for Medicaid.

In States which do not use a joint application for Medicaid and separate child health programs, the State agency or contractor that conducts the screening shall (1) inform the applicant that the child is potentially eligible for Medicaid; (2) provide the applicant with a Medicaid application and offer assistance in completing the application, including providing information about what, if any further information and/or documentation is needed to complete the Medicaid application process; and (3) promptly transmit the application and all other relevant information, including the results of the screening process, to the Medicaid agency for a final determination of Medicaid eligibility, in accordance with § 431.636.

It should be noted that under most circumstances, the term "promptly" means that the entire process (including screening and facilitation between SCHIP and Medicaid) for determining eligibility should be completed within the 45 day period. However, we recognize that there are cases where the timing of the process is beyond the control of the separate child health program. For example, if the process for determining Medicaid eligibility after a screen reveals that the family's income has changed, making them eligible for the separate child health program, we understand that the need to transfer paperwork back and forth between programs can take additional time beyond the 45 days.

Alternatively, under § 457.350(f), the State can establish other procedures to eliminate duplicative requests for information and documentation and

ensure that the applications and all relevant documents of children screened potentially eligible for Medicaid are transmitted to the Medicaid agency or staff and that, if eligible, such children are enrolled in Medicaid in a timely manner.

We also have added a section § 457.353(a) to require that States monitor and establish a mechanism to evaluate (1) the process established in accordance with § 457.350 to ensure that children who are screened potentially eligible for Medicaid apply for and, if eligible, enroll in that program and (2) the process established to ensure that the applications for a separate program of children who are screened potentially eligible, but ultimately determined by the Medicaid agency not to be eligible, for Medicaid are processed in accordance with § 457.340 of this subpart.

Data collection will need to be a part of any mechanism developed to effectively evaluate the screen and enroll process. For example, States will need to collect data on the number and percent of children applying for a separate child health program who are screened potentially eligible for Medicaid; the number of those screened potentially eligible for Medicaid who ultimately are determined to be eligible versus the number determined not to be eligible for Medicaid; the number of those children ultimately determined not to be eligible for Medicaid whose applications for the separate child health program are processed; etc. These data will help States and HCFA evaluate whether the procedures States adopt are accomplishing the goal of enrolling children in the appropriate program or whether modifications are needed.

We have modified the language in § 457.350(f)(5)(ii) to clarify that States must determine or redetermine the eligibility of a child initially screened eligible for Medicaid if the child's circumstances change and under § 457.350(e) another screening shows that the child does not appear to be eligible for Medicaid. We have added the phrase "does not appear to be" to reflect the fact that only the State Medicaid agency is authorized to actually determine that a child is ineligible for Medicaid. Contractors can only make a determination as to the likelihood of the child's eligibility for purposes of proceeding with the application for a separate child health program.

Second, we have added a new subparagraph at § 457.350(f)(5)(iii) to clarify that, in determining or redetermining the eligibility for a separate child health program of a child

screened potentially eligible, but ultimately determined not eligible, for Medicaid, the child may not be required to complete a new application, although it may supplement the information on the initial application to account for any changes in the child's circumstances or other factors that may affect eligibility.

We also have added a new subsection § 457.350(h) to require that States which have instituted a waiting list for the separate child health program develop procedures to ensure that the screen and enroll procedures set forth in § 457.350 have been complied with before a child is placed on the waiting list. This ensures that children who are eligible for Medicaid are not placed on a waiting list if a State has closed enrollment for its separate child health program. These requirements ensure that eligible children are enrolled in the appropriate program without delay and without unnecessary paperwork barriers. At the same time, they give States ample leeway to design the system that works best for them. No one system is prescribed, but States will need to monitor and evaluate how well their system is working, and they will be held accountable for ensuring that the system they have designed and implemented complies with the statutory and regulatory requirements.

Comment: We received one comment that the regulations should clearly indicate that a State may cease accepting applications for its separate child health program when enrollment is closed.

Response: The State may stop accepting applications as one method of administering an enrollment cap. If the State is using a joint application, which is also an application for Medicaid, then the State must have provisions to assure that the Medicaid eligibility determination process is initiated, even if enrollment in the separate child health program has been suspended. If, after a State plan that does not authorize an enrollment cap is approved by HCFA, the State opts to restrict eligibility by discontinuing enrollment, the State must submit a State plan amendment in accordance with §§ 457.60 and 457.65 of this final rule.

Comment: Two commenters suggested that the preamble reiterate that a child who must meet a spend down does not have "other coverage" and may be eligible for the separate child health program.

Response: We have not required States to screen for Medicaid eligibility under the medically needy groups described in section 1902(a)(10)(C) of the Act because of the uncertainty inherent in determining whether and

when a spend down has been met. A child who is not yet “medically needy” because he or she has not yet met the spend down requirements is not considered to be eligible for Medicaid for purposes of the screening requirement. However, an individual who could be eligible for Medicaid as medically needy with a spend down has a right to apply for Medicaid, and should be informed of the spend down category. If a child is eligible without a spend down or if it is determined that the spend down has been met, then the child would be eligible for Medicaid and would not be eligible for the separate child health program. Information about the State’s medically needy program must be included in the information provided to applicants for a separate child health program.

Comment: In response to our request for comments on the extent of the Medicaid “stigma” problem and possible solutions, several commenters noted that poor coordination between separate child health programs and Medicaid expansions contributes to the stigmatization of Medicaid. One commenter noted that many working people take pride in their achievements and posited that they prefer to pay their own way rather than participate in what they perceive as a public assistance program. This commenter felt that people’s desire for self-reliance is not an attitude that public policy can (or should) change.

According to the commenters, a program is more likely to be successful in insuring children if these attitudes are taken into account. Two commenters said that negative reactions to Medicaid are due to its historic association with welfare; discourteous or intrusive treatment by workers; difficult application processes; negative treatment by providers; negative personal experiences and those of friends and neighbors.

Several commenters suggested that the stigma can be alleviated by having a simple, joint enrollment process and creating a seamless environment. One commenter suggested that a non-public entity be allowed to enroll children in Medicaid. Another recommended that HCFA encourage States to offer applicants a choice of settings in which to be enrolled, because reliance on a public monopoly reinforces the stigma. Additional suggestions included giving both programs one name; adopting a joint application; eliminating asset tests; encouraging presumptive eligibility; expanding outreach and enrollment sites; eliminating face-to-face requirements; and offering a single application site. One commenter also

recommended that HCFA continue to research best practices and promote them.

One commenter suggested that ensuring that providers in both programs are paid adequately and that provider networks in both programs provide convenient access to high quality services is a critical step as well. We received one suggestion that HCFA assess the barriers to Medicaid enrollment in each State and develop and implement a State-specific plan to address and remove such barriers. Several commenters asserted that the situation is difficult to resolve given the current statutory requirements and suggested that HCFA fund a study and make suggestions for legislative changes.

Response: We appreciate the responses on the stigma issue and have incorporated many of them in our guidance and suggestions to the States. We will continue to research and promote best practices and note that many States have successfully eliminated or greatly limited the welfare stigma which sometimes is associated with Medicaid and have converted Medicaid to a program that operates as, and is perceived to be, a health insurance program.

We encourage States to continue to simplify their processes and eliminate barriers to facilitate enrollment and retention among eligible individuals. We also encourage States to employ outreach efforts geared toward changing the perception that Medicaid is “welfare.” We urge States to make clear in all their informational materials about the TANF cash assistance program that coverage under Medicaid or a separate child health program is not linked to TANF eligibility or enrollment and that, whether or not families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and any separate child health program.

8. Facilitating Medicaid Enrollment (§ 457.360)

Under section 2102(b)(3)(B) of the Act, States are required to ensure that children found through the screening process described above to be eligible for Medicaid apply for and are actually enrolled in Medicaid. We proposed in § 457.360(a) that the State plan must describe the reasonable procedures to be adopted to ensure that children found through the screening to be potentially eligible for Medicaid actually apply for and are enrolled in Medicaid, if eligible. Under proposed § 457.360(b), States must establish a process to initiate the Medicaid enrollment process for potentially Medicaid eligible children

and several options for States are provided.

We also proposed to require at § 457.360(c) that a State ensure that families have an opportunity to make an informed decision about whether to complete the Medicaid application process by providing full and complete information, in writing, about (1) the State’s Medicaid program, including the benefits covered and restrictions on cost-sharing; and (2) the effect on eligibility for coverage under the separate child health program of neither applying for Medicaid nor completing the Medicaid application process.

Comment: We received one comment that States should not be required to “ensure” that children enroll in Medicaid because States cannot dictate to families, but can only assist them.

Response: The statute specifically requires that States “ensure” that children are enrolled. It is correct that a family cannot be forced to apply for Medicaid and that States cannot ultimately “ensure” that an eligible child is enrolled. However, it is the responsibility of the State to remove barriers to enrollment, adopt procedures that promote enrollment of eligible children, and ensure that the family understands the benefits of Medicaid and the consequences of not applying for Medicaid.

Comment: We received a number of comments pertaining to the information about Medicaid which must be provided to families. One commenter stated that it was not reasonable to expect States to “ensure” that a family’s decision not to apply for Medicaid is an informed decision and that this could lead to costly litigation over whether the State has taken sufficient measures. A significant number of commenters were concerned that States would be required to provide “reams” of in-depth information about Medicaid and commented that general information ordinarily provided to any family interested in applying for Medicaid should be sufficient. Finally, one commenter recommended that information about the benefits of Medicaid be provided to adolescents in a format and language that can be easily understood by both the adolescent and the family.

Response: Sufficient information must be provided to families to enable them to make an informed decision about completing an application for Medicaid. We agree that information about Medicaid eligibility and the benefits of Medicaid should also be in a format that adolescents can understand as appropriate. We also note that the provision of information to families

under proposed § 457.360(c), section § 457.350(g) of the final rule, only applies for States that use a separate application for their separate child health plan and those using a joint application which permits families to check a box on the application to elect not to apply for Medicaid.

In some cases, the general information provided ordinarily to any family interested in applying for Medicaid may provide sufficient information about Medicaid itself for these purposes. However, the State must also inform the family about the effect on eligibility for the separate child health program if the family chooses not to apply for Medicaid or not to complete the Medicaid application process, as many families will not realize that they do not have a choice between programs.

We have reconsidered the use of the term “ensure” because we agree that States cannot “ensure” that a decision is an informed one, no matter how much or how understandable the available information. States can only make the information available in an accessible way. We have revised the regulation at new § 457.350(g) (proposed § 457.360(c)) to require that States provide sufficient information to enable the family to make an informed decision.

Comment: One commenter suggested that, because Medicaid eligibility may result in automatic referral to CSE, States should inform families applying for the separate child health program about the rights and responsibilities associated with being found eligible for Medicaid, including the assignment of medical support rights and the right to claim an exemption from the cooperation requirements. The commenter is concerned that a mother applying for SCHIP, where there is no need for contact with the noncustodial parent, may not mention that she has been subject to domestic abuse at the time of applying, and might be automatically referred to CSE when there is good cause for not being referred.

Response: A Medicaid application for a child should not result in a referral to the CSE agency absent the cooperation of a parent. We agree that whenever a Medicaid or separate child health program application is filed, the family should be informed about the services offered by the CSE, its opportunity to take advantage of these services, and whether additional information will be required. Cooperation with establishing paternity and pursuing medical support is *not* a condition of a child's eligibility for Medicaid. Parents can be asked whether they would like to pursue

medical support through CSE, but a cooperation in obtaining CSE cannot be required as a condition of a child's eligibility for Medicaid. If a parent also is applying for Medicaid, the parent should be informed of the acceptable reasons for refusing to cooperate and of the distinct consequences for the parent's and child's eligibility of not cooperating if none of the acceptable reasons applies.

Comment: One commenter noted that States should be given flexibility in the areas of application and enrollment. Another commented that the proposed regulations are overly prescriptive and exceed statutory authority by requiring States and SCHIP applicants to go through a tedious and administratively difficult process of obtaining a written waiver from applicants stating they do not wish to apply for Medicaid or complete a Medicaid application as required in proposed § 457.360(c).

Response: As discussed in the responses to several comments below, States have a great deal of flexibility in the areas of application and enrollment. There is no requirement that SCHIP programs ask families for a waiver; in fact, under title XXI, States do not have the option of enrolling children in the separate program if a Medicaid screen indicated the child may be eligible for Medicaid, even if a family waived their right to apply for Medicaid. States must inform families about the consequences for the child's coverage of not applying for Medicaid and develop systems to facilitate seamless enrollment in Medicaid for eligible children pursuant to § 457.350. Under § 457.350(f)(1), the State could suspend the child's application for the separate program unless or until a completed Medicaid application for that child is denied. This would preserve the child's initial application date and ensure follow-up on the part of the State SCHIP agency after the specified time period had elapsed.

Alternatively, a State may deny, or provisionally deny, the separate child health program application. As discussed earlier, if a State provisionally denies the application and the child is subsequently determined ineligible for Medicaid, the child's initial separate child health program application should be reactivated as soon as the SCHIP agency learns of the denial of Medicaid eligibility. The family would not need to provide any additional information (unless there has been a change in circumstances that could affect eligibility). If the child chooses not to apply for Medicaid, the denial or provisional denial under a separate child health program will stand (unless

the child's circumstances change and a new screen shows that the child no longer appears potentially eligible for Medicaid).

Comment: Several commenters were concerned that the application process for Medicaid would be a barrier to enrollment in a separate child health program. Some expressed concern that the proposed rule would fail to prevent States from using unnecessary administrative barriers and hostile or adversarial treatment by Medicaid eligibility workers as a means of discouraging families from successfully completing a Medicaid application and one urged HCFA to prevent States from requiring that applicants screened potentially Medicaid-eligible go through complicated, time-consuming and demeaning processes. Two recommended that HCFA prohibit States from making the process for applying for Medicaid more burdensome, onerous or time-consuming than the process for applying for a separate child health program. A few urged that the screen and enroll requirements be enforced, monitored, and evaluated to ensure that all children eligible for Medicaid are reached. One of the commenters urged HCFA to set high standards to ensure that States actually enroll screened children in Medicaid.

Response: Section 2102(b)(3)(B) of the Act requires States to describe in their State plan their procedures for ensuring that children screened potentially eligible for medical assistance under the State Medicaid plan under title XIX are enrolled in Medicaid. We have implemented that statutory provision at § 457.350(a)(1). A simple referral to the Medicaid agency is not enough to meet this requirement. In § 457.350, we require that States take reasonable action to facilitate the Medicaid application process and to promote enrollment of eligible children into Medicaid.

We do not have the statutory authority to require any particular application process, or that the Medicaid application process be no more difficult than the application procedures for separate child health programs. However, we appreciate the commenters' concerns and encourage States to examine their administrative systems and to simplify and minimize barriers in their application and enrollment processes for both Medicaid and separate child health programs to the extent possible. We are pleased that most States are moving in this direction and will continue to provide technical assistance on this matter as needed.

Given Congressional concern that title XXI funds not be used to supplant existing health insurance coverage, ensuring compliance with the screen and enroll requirements of title XXI is a high priority for HCFA and will be strictly monitored, evaluated, and enforced. As previously discussed, we have added a new § 457.353(a) to require States to monitor and establish a mechanism to evaluate the processes adopted by the State to implement the screen and enroll provisions of § 457.350.

Comment: Two commenters recommended that States be required to send a notice after an initial screen finds potential Medicaid eligibility.

Response: The State needs to provide written notice of any determination of eligibility under § 457.340(d). If the State determines that an applicant is ineligible for coverage under its separate child health program, the State must provide written notice of that determination. In addition, under § 457.350(g) the State must provide families with information to enable them to make an informed decision about applying for Medicaid; and under § 457.350(f)(3), if a State does not use a joint application for Medicaid and its separate child health program, applicants that are screened potentially Medicaid-eligible must be given notice that they have been found potentially eligible for Medicaid, and be offered assistance in completing a Medicaid application (if necessary), and provided information about what is required to complete the Medicaid application process.

Comment: We received two comments related to the effective date of an application. One commenter requested that the regulations clarify that if a joint application is used, the date of the application for a separate child health program is also the date of application for Medicaid. One commenter believed that if an application for the separate child health program is denied, the State must provide notice to the applicant and must also continue to process the Medicaid application within the 45-day time frame.

Response: If a State uses a joint application for Medicaid and its separate child health program, the date of application for Medicaid may or may not be the same as the date of application for the separate program. As indicated earlier, this is because the State agency that determines eligibility for Medicaid may not be the same entity that determines eligibility for the separate program. In some cases, it may not be reasonable to hold the Medicaid agency responsible for determining

eligibility within 45 days when it could not have initiated the determination process until the application was transmitted from the entity administering the separate child health program.

The SCHIP entity's responsibility in this case is to promptly transmit the application to the Medicaid agency immediately following the screen. Under most circumstances, the term "promptly" means that the entire process (including screening and facilitation between the separate child health program and Medicaid) should be completed within 45 days. However, we recognize that there are also circumstances where the timing of the process is beyond the control of the separate child health program and the separate child health program. For example, if the process for determining Medicaid eligibility after a screen reveals that the child's family income has changed, making them eligible for the separate child health program, we understand that the transfer back and forth between programs can take additional time.

If a State uses separate applications for its separate child health program and Medicaid, States can but are not required to establish the date the separate application was filed as the effective date of filing for Medicaid. States have flexibility under the Medicaid program to establish the effective date of a Medicaid application. The regulations at § 431.636 of this chapter do require that the SCHIP agency and the Medicaid agency coordinate to design and implement procedures that are developed to coordinate eligibility to ensure that eligible children are enrolled in the appropriate program in a timely manner.

Comment: Two commenters recommended that the regulations require that, even if a separate application is used for the separate child health program, the application form and any supporting verification must be transmitted to the appropriate Medicaid office for processing without further action by the applicant to initiate a Medicaid application. One commenter recommended that if an applicant is required to take any additional steps in order to apply for Medicaid, that the Medicaid agency inform the family of the steps it must take.

Response: As discussed above, under § 457.350(f)(3), States that use a separate application must provide an applicant screened potentially eligible for Medicaid with a Medicaid application; offer assistance in completing the

application, including providing information about any additional information or documentation needed to complete the Medicaid application process; and send information and all relevant documentation obtained through the screening process to the appropriate Medicaid office or to Medicaid staff, to begin the Medicaid application process. An application for Medicaid would then be processed in accordance with Medicaid rules and regulations. Documentation (or photocopies) must be forwarded to the Medicaid agency along with other information wherever feasible. The family cannot be required to repeat information or provide documentation more than once. However, a separate child health application is not an application for Medicaid unless the State allows it to be used as such. Some States do use the separate child health program application as the Medicaid application when a child is screened as potentially eligible for Medicaid. This practice relieves the family and the State of the need to complete and review another application form.

As part of meeting their obligations under section 2102(b)(3)(B) of the Act, States must adopt reasonable procedures to ensure that a Medicaid application for children screened potentially eligible for Medicaid is completed and processed (provided that the family has not indicated that it does not wish to apply for Medicaid for the child). The obligations of the Medicaid agency in meeting this requirement are set forth in § 431.636 and discussed further in subpart M of this preamble, "Expanded coverage of children under Medicaid and Medicaid coordination."

Comment: A number of commenters suggested that the procedures in the regulations for facilitating Medicaid enrollment should specifically require that application assistance include bilingual workers, translators and language appropriate material or that the requirements of title VI and the ADA should be explained in the preamble. One commenter recommended that this include examples of how States and contracted entities can comply with these requirements.

Response: As required by § 457.130, the State plan must include an assurance that the State will comply with all applicable civil rights requirements. In addition, § 457.110 requires that States provide to potential applicants, applicants and enrollees information about the program that is linguistically appropriate and easily understood. Such materials and services, as well as compliance with the ADA, are required and important if

States are to effectively reach and enroll all groups of eligible children. We elected not to explain in detail all applicable civil rights requirements identified under § 457.130. However, interested parties can obtain additional information on these requirements by contacting the U.S. Health and Human Services' Office for Civil Rights.

9. Application for and Enrollment in a Separate Child Health Program § 457.340 (Proposed § 457.361)

Because we believe that the provisions of this section are closely related to those contained in proposed 457.340, in this final rule, we have incorporated the provisions of these two sections in the final regulation at § 457.340. However, we will respond to comments to proposed § 457.361 here.

In this section, we proposed to require that States afford individuals a reasonable opportunity to complete the application process and offer assistance in understanding and completing applications and in obtaining any required documentation. Furthermore, we proposed to require that States inform applicants, in writing and orally if appropriate, about the eligibility requirements and their rights and responsibilities under the program.

We noted in the preamble to the proposed rule that, although not specifically addressed in statute, a State may choose to provide a period of presumptive eligibility during which services are provided, although actual eligibility has not been established.

We proposed that the State must send each applicant a written notice of the decision on the child health application and that the State agency must establish time standards, not to exceed forty-five calendar days, for determining eligibility and inform the applicant of those standards. In applying the time standards, the State must count each calendar day from the day of application to the day the agency mails written notice of its decision to the applicant. We also proposed that the State agency must determine eligibility within the State-established standards except in unusual circumstances and that the State must specify in the State plan the method for determining the effective date of eligibility for a separate child health program.

In addition to the changes made in response to the comments discussed below, we have modified the language in § 457.361(c) (§ 457.340(d) in this final regulation) to clarify that States must notify families whenever a decision affecting a child's eligibility is made—whether the decision involves denial, termination or suspension of eligibility.

In the case of a termination or suspension of eligibility, the State must provide sufficient notice, in accordance with § 457.1180, to enable the child's parent or caretaker to take any appropriate actions that may be required to allow coverage of the child to continue without interruption. This clarification has been added in response to comments in order to ensure that children do not experience an unnecessary break in coverage because they have reached the end of an enrollment period.

Comment: Several commenters stated that HCFA should require States to notify the public of the priority standards, if any, for enrollment; inform individuals of their status on any waiting list; and maintain sufficient records to document that favoritism or discrimination does not occur in selecting individuals for enrollment.

Response: As discussed in the preamble to § 457.305, above, if a State plans to institute a waiting list or otherwise limit enrollment, it must include in its State plan a description of how the waiting list will be administered, including criteria for how priority on the list will be determined. In addition, § 457.110 requires States to inform applicants about their status on a waiting list.

Comment: We received several comments on the proposed requirement that a State determine eligibility under a separate child health program within 45 days. One commenter stated that the date of the application should not be the beginning of the 45 day period but rather the date that the application is received in the separate child health program eligibility office as there could be a delay for mailed-in applications. Another commented that the 45-day requirement does not take into account delays in obtaining necessary verifications from third parties such as employers or insurers. They suggested adding "or other party with information needed to verify the application [delays * * *]" or just requiring States to determine eligibility in a timely manner. A third supported establishing a 45-day time limit and prohibiting the use of time standards as a waiting period, but recommended that the regulations provide more specificity regarding when notice of rights and responsibilities must be given and a notice of decision provided. Another commenter felt that the 45-day requirement should be removed, that mirroring Medicaid is burdensome and costly, and allowing mail-in and drop-off applications may mean it will take longer to reach people to get all the necessary information.

Response: We have not changed the requirement in § 457.340(c) (proposed § 457.361(d)) that States must determine eligibility for a separate child health program within 45 calendar days (or less if the State has established a shorter period) from the date the application is filed. We have, however, clarified § 457.340(c)(2) (§ 457.361(d) in proposed rule) to require that States determine eligibility and issue a notice of decision promptly, but in any event not to exceed the time standards established by the State. This is consistent with the requirement that child health assistance be provided in an efficient manner, and that the 45-day period—or other time period specified by the State—may not be used as a waiting period. States have flexibility in deciding when an application is considered filed.

We agree that States should not be held responsible for delays caused by third parties beyond the State's control and have accommodated that concern in § 457.340(c)(2). We also have revised § 457.340(b) to specify that the notice of rights and responsibilities must be provided at the time of application. This ensures that families have the information they may need to proceed with the application process and successfully enroll their child.

Comment: We received two comments objecting to the requirement in § 457.340(a) that States assist families in obtaining documentation. They commented that States are not in a position to do this and that the requirement has the potential for enormous administrative burden.

Response: We will not be removing the phrase from the regulation, but will offer clarification related to this provision as we think the commenter may have misinterpreted the proposed rule. We expect that, in offering application assistance, the State or contractor for the separate child health program will provide assistance to applicants in understanding what documentation is needed to complete their applications and, to the extent possible, will assist applicants in determining where they might obtain the needed information. For example, if the State's application process requires verification of income and the applicant does not understand how they can prove their income, we would expect the State or the individual providing application assistance to be able to inform the family of the type of documentation (e.g., pay stubs or W-2 forms) needed and where the applicant might be able to obtain that information (e.g., from their employer). We do not expect a State to literally perform the

task of obtaining the documentation for the applicant, unless it so chooses or the document is readily available to it, and agree with the commenters that such a requirement would be administratively burdensome. Most States have produced application materials and program brochures and operate telephone help lines that provide the type of assistance required by the regulation.

10. Eligibility and Income Verification (§ 457.360)

In this final regulation, we have moved two provisions of proposed § 457.970, concerning eligibility and income verification, to new § 457.360. In proposed § 457.970, we proposed to require that States have in place procedures designed to ensure the integrity of the eligibility determination process, and to abide by verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations.

We proposed that States have flexibility to determine these documentation and verification requirements. In the preamble, we encouraged States to adopt procedures that ensure accountability while permitting self-declaration to minimize barriers in the application and enrollment process.

We also noted at § 457.970(c) that States with separate child health programs may choose to use the Medicaid income and eligibility verification system (IEVS) for income and resources, although they are not required to do so.

Finally, in § 457.970(d) we proposed to allow States to terminate the eligibility of an enrollee for “good cause” (in addition to terminating eligibility because the enrollee no longer meets the eligibility requirements)—*e.g.*, providing false information affecting eligibility. Under the proposed regulations, the State would have to give such enrollees written notice setting forth the reasons for termination and providing a reasonable opportunity to appeal, consistent with the requirements of proposed § 457.985.

Note that, in this final regulation, we have eliminated any specific reference to income verification systems, as income requirements are but one of a number of requirements for eligibility under a separate child health program.

Comment: One commenter expressed support for the flexibility HCFA gives States for verifying eligibility and income. Another recommended requiring that States’ eligibility and income verification processes be designed to minimize barriers to and facilitate enrollment, and that the

regulations explicitly provide that States may use self-declaration of income and assets. A third suggested that HCFA should include a description of the opportunity that States have to use innovative quality control projects to ensure that allowing families to self-declare income does not increase the rate of erroneous enrollment.

Response: We appreciate the support for the flexibility afforded to States and encourage States to adopt eligibility and income verification procedures that do not create barriers to enrollment. At the same time, States must have effective methods to ensure that SCHIP funds are spent on coverage for eligible children. We note that States can use their discretion in establishing reasonable verification mechanisms and have included this in the regulation text at § 457.360(b). We also encourage the creation of innovative projects to promote program integrity.

As stated in the preamble to the proposed rule, we also encourage States to develop eligibility verification systems using self-declaration or affirmation, and have decided to include this in the regulation text at § 457.360(b), to eliminate any question about the rule. States may use the existing IEVS system to verify income, as long as the information was provided voluntarily. While States may ask for voluntary disclosure of Social Security numbers, disclosure of such information cannot be made a condition of eligibility. States may use existing IEVS systems to verify income, as long as the information was provided voluntarily. We note that the integrity of a system which relies on self-declaration can be ensured through a variety of techniques. For example, a State could conduct a random post-eligibility check, requiring some applicants to provide documentation, or it could run computer matches of information provided by applicants against information available to the State through other sources.

Finally, we have deleted proposed § 457.970(a)(2) (requiring compliance with the verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations) because it does not provide meaningful guidance to States on what they can and cannot do in designing their verification systems. If the system proposed violates other Federal laws or regulations, we will work with the State to bring its system into compliance.

Comment: One commenter noted his concern that the regulation authorizes States to terminate coverage of children for misconduct of a parent/caretaker and

suggested that HCFA revise the definition of “good cause” to be more limiting. This commenter also noted his concern that the reference in proposed paragraph (d) to termination for good cause is troubling. The example of good cause as reporting false information on the application form does not seem to be good cause for a child losing benefits if the false statement does not affect the child’s eligibility. The commenter stated that this kind of standard is highly subjective and susceptible to abuse given the large amount of discretion States already have in administering their plans.

Response: We agree with the commenter’s concern and have deleted the good cause provisions from the regulation text accordingly. Children should not lose eligibility, as long as they meet the eligibility standards under the approved State plan and consistent with title XXI requirements. Further discussion of these issues can be found in Subpart K.

11. Review of Adverse Decisions (§ 457.365)

Finally, we proposed in the NPRM to require that States provide enrollees in separate child health programs with an opportunity to file grievances and appeals for denial, suspension, or termination of eligibility in accordance with § 457.985. In an effort to consolidate all provisions relating to review processes in new subpart K, we have removed proposed § 457.365. Comments on proposed § 457.365, are addressed in full in Subpart K—Applicant and Enrollee Protections.

D. Subpart D—Coverage and Benefits: General Provisions

1. Basis, Scope, and Applicability (§ 457.401)

As proposed, this subpart interprets and implements section 2102(a)(7) of the Act, which requires that States make assurances relating to certain types of care, including assuring quality and appropriateness of care and access to covered services; section 2103 of the Act, which outlines coverage requirements for children’s health benefits; section 2109 of the Act, which describes the relation of the SCHIP program to other laws; section 2110(a), which describes child health assistance; and certain provisions of section 2110(c)(6) of the Act, which contains definitions applicable to this subpart. The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to Medicaid expansion programs even when funding is based

on the enhanced Federal medical assistance percentage. We received no comments on this section and have retained the language in this final rule.

2. Child Health Assistance and Other Definitions (§ 457.402)

Proposed § 457.402 set forth the definition of child health assistance as specified in section 2110(a) of the Act. We did not propose to include any additional services in the definition of child health assistance or attempt to further define the services set forth in the Act in order to give States flexibility to provide these services as intended under the statute. Accordingly, we proposed that the term “child health assistance” means payment for part or all of the cost of health benefits coverage provided to targeted low-income children through any method described in § 457.410 for any of the following services as specified in the statute:

- Inpatient hospital services.
- Outpatient hospital services.
- Physician services and surgical services.
- Clinic services (including health center services) and other ambulatory health care services.
- Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
- Over-the-counter medications.
- Laboratory and radiological services.
- Prenatal care and pre-pregnancy family planning services and supplies.
- Inpatient mental health services, other than inpatient substance abuse treatment services and residential substance abuse treatment services, but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
- Outpatient mental health services, other than outpatient substance abuse treatment services, but including services furnished in a State-operated mental hospital and including community-based services.
- Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).
- Disposable medical supplies.
- Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services,

day care services, respite care services, training for family members and minor modification to the home.)

- Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.
- Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Case management services.
- Care coordination services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.
- Hospice care.
- Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law; performed under the general supervision or at the direction of a physician; or furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
- Premiums for private health care insurance coverage.
- Medical transportation.
- Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
- Any other health care services or items specified by the Secretary and not excluded under this subchapter.

We proposed to define the terms “emergency medical condition,” “emergency services,” and “post-stabilization services” to give full meaning to the statutory requirement at section 2102(a)(7)(B) of the Act that States assure access to emergency services consistent with the President’s directive to Federal agencies to address the Consumer Bill of Rights and Responsibilities, which includes the right to access to emergency services. We proposed to define the term “emergency medical condition” as a medical condition manifesting itself by

acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child;
- Serious impairment of bodily function; or
- Serious dysfunction of any bodily organ or part.

We proposed to define the term “emergency services” as covered inpatient or outpatient services that are furnished by any provider qualified to furnish emergency services without requirement for prior authorization and needed to evaluate or stabilize an emergency medical condition. Because these terms are used throughout the regulation, we have moved the definitions of “emergency services” and “emergency medical condition” to § 457.10, the overall definitions section. The comments and responses related to these definitions are addressed in § 457.10.

We proposed to define “post-stabilization services” to mean covered medically necessary non-emergency services furnished to an enrollee after he or she is stabilized related to the emergency medical condition.

We proposed to define “health benefits coverage” as an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services.

Comment: A commenter agreed that our definition of “child health assistance” is appropriate and considered the specific identification of advanced practice nursing services at § 457.402(a)(14) to be crucial to ensuring that children in fact receive the care to which they are entitled by statute.

Response: We appreciate the commenter’s support for our definition. The proposed regulation set forth the definition of child health assistance as specified in section 2110(a) of the Act. The provision of advanced practice nursing services is specifically identified in that section as a coverable service.

Comment: One commenter questioned why well-baby care, well-child care and immunizations are not explicitly included in the list of definitions. These benefits are the cornerstone of pediatric care and the commenter indicated that it is important that they are explicitly included wherever appropriate.

Response: Section 2102(a)(7) of the Act provides the authority for requiring that well-baby and well-child care and immunizations be included under every State plan. Well-baby and well-child care and immunizations were not specified in the statutory definition of "child health assistance" at section 2110 of the Act, although they clearly fall within this definition of "child health assistance." Additionally, well-baby and well-child care are not separate categories of services, but can include services that are in any or all of the separately defined categories of services. However, because these terms are used throughout the regulation we have included them in the definitions at § 457.10. These services are also discussed at §§ 457.410 and 457.520.

Comment: One commenter was concerned about the definition of post-stabilization services and the language in the preamble stating that HCFA would expect States and their contractors to treat post-stabilization services in the same manner as required for the Medicare and Medicaid programs, while recognizing that not all such services would be necessarily covered by the State for purposes of SCHIP.

While the commenter did not object to permitting States to apply to separate child health programs an interpretation of post-stabilization services that is the same as that under Medicaid and Medicare, they believed that HCFA should give States flexibility to treat the coverage of post-stabilization services differently depending upon the structure of the State program. A State that designs its separate child health program to mirror its Medicaid program would want to retain the same interpretation for both programs. However, a State that models its program after commercial coverage would want to adopt an interpretation that is applicable to commercial coverage that is offered by MCEs. Such flexibility would be particularly important if the State decides to provide coverage to SCHIP eligibles by purchasing coverage from employer group health plans to cover children. In those cases, the emergency services requirement should parallel those applicable to the employer's group health insurance coverage. The commenter recommended that the proposed regulation be revised to reflect this needed flexibility.

To the extent that States adopt or HCFA requires use of the interpretation of the post-stabilization services requirements applicable under the Medicaid and Medicare programs, the commenter reiterated its comments on

the Medicaid managed care notice of proposed rulemaking and the interim final Medicare+Choice regulation. The issue of concern to this commenter was whether the requirement that Managed Care Entities (MCEs) respond to requests for approval of post-stabilization services within one hour is reasonable.

The commenter expressed considerable concern about requirements for post-stabilization care for MCEs, particularly the requirement that MCEs respond to requests for approval of post-stabilization care within one hour. The commenter suggested conditions to moderate the effect of this requirement.

Response: We agree with the commenter that States should have the flexibility to treat coverage of post-stabilization services differently depending on the health benefits coverage elected by the State. The preamble to the proposed rule may have been misleading by appearing to require the provision of post-stabilization services under a separate child health program, therefore, we have removed the references to post-stabilization services, covered or otherwise, from the final rule. We hope that this will minimize confusion.

Comment: Several commenters on proposed § 457.995 had other concerns regarding the provision of post-stabilization services for individuals in managed care. These commenters expressed concern that managed care organizations should be allowed to control their own networks. A payment network needs the flexibility to require a patient to be transferred to an appropriate facility within its network after the emergency has been stabilized. According to these commenters, this regulation takes the control of non-emergency services away from the network and gives it to a non-network provider and could defeat the concept of managed care. The commenters believed that when emergency care is provided outside of the MCE network, it is usual and customary for the patient to be transferred to an appropriate facility within their MCE network for required post-stabilization services.

Response: Proposed § 457.995(d), the provision in the overview of beneficiary rights referencing post-stabilization services, has been removed from the regulations text along with the rest of § 457.995 for the sake of clarity and consistency.

Comment: One commenter noted that the preamble to the proposed rule indicates that HCFA considered defining transportation to include coverage for transportation to more than primary and preventive health care as

stated in the law. However, the commenter noted that HCFA decided to leave the option of establishing the definition to the States. The commenter regarded transportation as including urgent and emergent care and that transfer/transport to a hospital or health facility for urgent and emergent care should be included in a child's health benefit package.

Response: Under the list of services in section 2110(a) of the Act and § 457.402 of this final regulation, transportation is mentioned in two different items: (26) medical transportation and (27) enabling services (such as transportation, * * *). While coverage for transportation services is not required, almost every State already provides coverage for emergency transportation under its State plan. Therefore, we do not see lack of coverage of this service as a problem and will not further define transportation services.

Comment: We received several comments on proposed § 457.402(a)(26), redesignated as paragraph (27), which provides for enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals. One commenter indicated that States should be required to fund community health centers to provide outreach activities and enabling services such as translation and transportation (rather than, or in addition to, outreach costs that are reimbursed under administrative accounts).

Several other commenters indicated that the phrase "outreach services * * *" only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals" is ambiguous and requested clarification. They noted that this phrase could be read to permit a State to pay primary health providers such as health centers to conduct outreach activities to find eligible children as part of their overall child health assistance services (rather than, or in addition to, outreach costs that are reimbursed under administrative accounts). The commenter noted that this is important because the SCHIP statute caps States' overall administrative costs and thus has been viewed as providing insufficient funds to support the types of outreach efforts that experts say are necessary to find eligible children. To the extent that the phrase "outreach * * *" to eligible low-income individuals" is interpreted as the identification of eligible children, then this represents an important option

for States and health centers. States could build outreach funds into their payments to SCHIP primary care providers, along with funding for other forms of enabling services, such as translation and transportation costs.

In the context of payment to primary health care providers, one commenter also indicated that States could build funds for outreach and enabling services into their payments to SCHIP primary care providers. The commenter indicated that community clinics and health centers in its State are encountering difficulties and confusion when being audited for purposes of receiving cost-based reimbursement from the State.

Response: In developing their State plans, States determine their own providers. We cannot require that community health centers be funded to provide outreach and enabling activities. The language of proposed § 457.402(a)(26) was taken directly from the language at section 2110(a)(27) of the Act. Enabling services, including outreach to assist children's access to primary and preventive care, are one of the types of services States may choose to provide as part of the "child health assistance" that meets the requirements of section 2103 of the Act. We note that under the terms of section 2110(a) and 2110(a)(27), these services must be delivered to "targeted low-income children" who are "eligible" for "child health assistance" under the State plan. Therefore, when enabling services are provided as part of the health benefits coverage for children who are found eligible and enrolled, these services would not be subject to the 10 percent cap on administrative expenditures under 2105(c) of the Act. However, outreach initiatives to potentially eligible children are subject to the 10 percent cap in accordance with section 2105(a)(2)(C) of the Act. We do not understand the commenter's specific concerns regarding difficulties in receiving cost-based reimbursement in the State's community clinics and health centers so we are unable to respond to this comment. (We note that, in this final rule, we have listed physician services and surgical services (proposed § 457.402(a)(3)) separately as paragraphs (3) and (4), respectively. As a result, the services listed at paragraphs (a)(4) through (a)(27) have been redesignated as paragraphs (5) through (28). Enabling services are now listed at paragraph (27).)

Comment: One commenter noted its belief that the preamble should encourage States, in selecting among benefits to cover, to consider the needs of different age groups, their varying

health status and patterns of morbidity and mortality, the impact of developmental states on their needs and their patterns of utilization. They observe, for example, that coverage of over-the-counter medications may be of particular benefit to adolescents. Also, eating disorders are more common among adolescents than younger children, and family planning services should include a choice among all contraceptive methods and options.

Response: We concur with the commenter and encourage States to consider the populations they are serving and the needs of different age groups when designing their benefit package States need only cover medically necessary and appropriate services, but the statute at section 2102(a)(7) and the regulations at § 457.495, specifically require States to specify the methods they will use to assure appropriate care.

Comment: Two commenters noted that the language on services in the proposed rule was set out identically to the language in the statute. The commenters were concerned that the definition of both inpatient and outpatient mental health services excludes substance abuse treatment services, which are listed separately in the statute and the regulation. One commenter was concerned that this separation means only that payment may be made for these services, not that payment shall be made for these services and believes that States should be encouraged to consider their inclusion for comprehensive treatment for adolescents with co-occurring mental and substance abuse disorders.

Similarly, another commenter is concerned that the separation of outpatient substance abuse treatment services may allow the provision of outpatient mental health services but not the provision of outpatient substance abuse services, but would include services furnished in a State-operated mental hospital and community-based services. The commenters indicated that substance abuse impacts a significant number of children in their States and rather than removing this important benefit, they recommended that the regulations need to encourage and even highlight the importance of offering this benefit.

The commenter noted that while the listings for mental health inpatient and outpatient services in the regulations specifically exclude substance abuse services, these services are listed separately from inpatient and outpatient mental health services. The commenter called attention to this because of the high incidence of co-occurring disorders

among adolescents with presenting symptoms of one or the other. Even though these services lack the 75 percent actuarial measure required when mental health services (and/or prescription drugs, vision and hearing services) are included, States should consider their inclusion for comprehensive treatment of adolescents with co-occurring mental and substance abuse disorders.

Response: We appreciate the commenter's view about the importance of respite care services. As we have indicated previously, the proposed rule at § 457.402 mirrors the language of section 2110(a). Therefore, inpatient mental health services and inpatient substance abuse treatment services, as well as outpatient mental health services, and outpatient substance abuse treatment services are listed separately in the regulation as they were in the statute. States choose to cover services from the list of services under the definition of "child health assistance" when they select a health benefits coverage option under § 457.410. The statute supports mandating that only three types of services, well-baby and well-child services, immunizations, and emergency services, be included in all SCHIP plans regardless of the type of health benefits coverage chosen. HCFA encourages States to provide inpatient and outpatient substance abuse services. A State may choose to provide inpatient mental health and substance abuse services; however the statute provides flexibility for the States in determining the scope of covered benefits.

We do, however, call the commenter's attention to the requirement in § 457.120 of the regulations for ongoing public input in the development and implementation of SCHIP plans. Comments and concerns about benefits and coverage should be directed to and taken under consideration by the State SCHIP agency. We encourage States to consider the populations they are serving and the needs of different age groups when designing their benefit packages.

Comment: One commenter particularly noted the inclusion in § 457.402 of "respite care services and training for family members," which are especially relevant to families with children with severe and persistent mental illness or brain disorders. The commenter stated that it would appreciate attention being called to these services' eligibility for coverage and relevance in plans that offer supplemental mental health services, in addition to other services, "i.e., respite care, advanced practice nurse services,

and pediatric nurse services * * * in a home, school or other setting.”

Response: As we have indicated previously, States that implement separate child health programs are given broad flexibility to design their benefit packages. We encourage commenters to work with their States to assure that valuable health care services are made available to children to the extent possible in each State.

Comment: One commenter recommended § 457.402 be deleted because the statute provides States with flexibility in the design of the SCHIP benefit package and this section implies that coverage for certain services should be available under SCHIP when it is not required by statute and may not be included in the state-designed benefit package.

Response: Section 2110 of the Act allows for payment for part or all of the cost of health benefits coverage (as defined at § 457.10) for any services listed in section 2110(a) of the Act as implemented in § 457.402. These provisions do not indicate that States must provide all of these services; rather, they list the array of services for which payment may be made. We disagree with the commenter and have not deleted this section from the proposed rule.

3. Health Benefits Coverage Options (§ 457.410)

Under the authority of section 2103 of the Act, at proposed § 457.410, we listed the four options a State has for obtaining health benefits coverage for eligible children. Specifically, we proposed that States may choose to provide benchmark coverage, benchmark-equivalent coverage, existing comprehensive State-based coverage, or Secretary-approved coverage. These four options are described at §§ 457.420 through 457.450.

Based on the authority of section 2102(a)(7) of the Act, we also proposed at § 457.410(b) to require that a State must obtain coverage for well-baby and well-child care, immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), and emergency services. We noted that the State must cover these services even if coverage for these services is not generally included in the health benefits coverage option selected by the State.

We proposed to define well-baby and well-child care for purposes of cost sharing at proposed § 457.520(b), but we proposed to allow States to define well-baby and well-child care for coverage purposes. We encouraged States, however, to adopt the benefits and

periodicity schedules recommended by a medical or professional organization involved in child health care when defining well-baby and well-child care coverage.

Comment: Two commenters supported the requirement that States use the ACIP schedule for immunizations under their separate child health programs. However, many commenters disagreed with the proposal that States be required to follow the immunization schedule of the ACIP, particularly because they are not allowed to participate in the VFC program. It was suggested that States should be able to adopt their own immunization periodicity schedules. One commenter suggested that we rewrite this section to require “immunizations as medically necessary” rather than require that immunizations be provided according to the ACIP schedule. Several commenters suggested that a State that utilizes existing commercial health plans may not use any particular standard immunization schedule or may follow other professional standards. One commenter mentioned that its State uses another standard, the recommended childhood immunization schedule jointly adopted by the American Academy of Pediatrics (AAP), the ACIP, and the American Academy of Family Physicians (AAFP).

Response: Section 2102(a)(7)(A) requires that a State child health plan include a description of a State’s methods to assure the quality and appropriateness of care, “particularly with respect to * * * immunizations provided under the plan.” In order to ensure that all SCHIP children are appropriately immunized, States should use a uniform, nationally recognized schedule of immunizations. The ACIP schedule referred to in the proposed rule is a harmonized schedule approved by the ACIP, the AAP, and the AAFP. It is referred to as the “Childhood Immunization Schedule of the United States.” The AAP and AAFP no longer develop and maintain separate immunization schedules but rather use the harmonized ACIP schedule. This ACIP schedule is the same as the standard referenced by one of the commenters as the schedule relied on by its State. States should use the ACIP schedule because it reflects the current standards of these pediatric specialty providers who are the recognized authorities in childhood immunizations.

Comment: Several commenters expressed their belief that requiring SCHIP programs to use the ACIP immunization schedule is overly prescriptive and has no basis in the

statute. According to one commenter, the only statutory limit on States’ discretion is found in section 2102(a)(7)(A), which indicates that the State plan must include a description of the methods used to assure the quality and appropriateness of care, particularly with respect to immunizations. The commenter cited Executive Order 13132 on federalism, and asserted that, consistent with that authority, States should be permitted to select their own immunization standards unless HCFA can demonstrate both a need for a federal standard and that it has considered alternatives that would preserve the States’ prerogatives.

Response: As described in the response to the previous comment, section 2102(a)(7)(A) of the Act provided authority to require immunizations in accordance with the recommendations of ACIP. Therefore, the requirement to use the ACIP schedule is not a violation of E.O. 13132. The ACIP schedule is a national standard developed and approved by three national medical organizations involved in child health care services, the ACIP, the AAP and the AAFP. These organizations use the harmonized ACIP immunization schedule and no longer use separate immunization schedules. Requiring coverage for appropriate immunizations at appropriate times, as the ACIP schedule recommends, does not place undue burden on States given the importance of childhood immunizations. In fact, it releases States from the burden of having to develop or choose their own individual schedules and establish the adequacy of those schedules with respect to title XXI statutory requirements. Given the unique nature of infectious diseases, and the mobility of the population across State lines, it is necessary to require a uniform approach to immunizing children across all States.

Comment: One commenter believed the 90-day requirement explained in the preamble to the proposed rule for States to adhere to any changes in the ACIP recommendations is inappropriate. The current policy is that States have 90 days from the publication of the revised ACIP schedule in the Morbidity and Mortality Weekly Report to implement those changes in their programs. The commenter believed that this requirement fails to recognize the realities of effectuating such a change in benefits. States should have until the end of the current contract period but in no case longer than one year to comply with any ACIP changes.

Response: It is essential for children to receive vaccines according to the most current ACIP recommendations in

order to maximize children's health, minimize morbidity and mortality, and reduce costs of treating preventable disease. In addition, good public health policy argues for consistent adoption of vaccine recommendations across all States in order to minimize the potential for transmission of communicable disease.

Comment: One commenter expressed its opinion on the importance of children in separate child health programs receiving all necessary immunizations and of vaccines being incorporated in all benefit packages. The commenter also suggested two ways that States may provide immunizations through their SCHIP programs without opening up the VFC program: (1) a State may add on payments for the provision of immunizations through participating MCEs; or (2) the State may declare that children enrolled under a separate child health program are State vaccine eligible. The State may then purchase the vaccines at the Federal contract price and distribute them to SCHIP providers as it currently does for Medicaid providers. The commenter stated that expenditures under either of these options would be matched by the Federal government at the SCHIP enhanced matching rate and would not count as administrative expenditures under the 10 percent cap. Additionally, the commenter believed that the State should require that plan contracts include provisions that require plans to provide and cover additional expenses for vaccines that are approved and recommended for all children during the life of the contract.

Response: We agree with the commenter that children in separate child health programs should receive all recommended immunizations, as should children in Medicaid expansion and combination programs. Also, regardless of the type of child health insurance program the State chooses, we agree with the suggestion that MCE contracts should provide that the MCEs furnish all vaccines, including new vaccines, recommended during the term of the contract.

However, regardless of whether the State chooses to include such a contract provision, States must furnish vaccines in accordance with the recommendations of the ACIP. States should furnish newly recommended vaccines to all eligible children within 90 days after the recommendation is published in Morbidity and Mortality Weekly Report. This report is available over the Internet at www.cdc.gov/mmwr.

We outlined ways that States could take advantage of the Federal discount contract price for vaccines in a letter

dated June 25, 1999 to all State Health Officials. As stated in that letter, expenditures for vaccines will be matched by the Federal government at the enhanced SCHIP matching rate and will not count as expenditures subject to the 10 percent cap on administrative expenditures under section 2105(c)(2) of the Act, regardless of whether the State takes advantage of the Federal discount contracts.

Comment: Many commenters recommended that HCFA reconsider its position on the Vaccines For Children (VFC) program for various reasons. One commenter indicated that in light of national immunization goals not yet having been achieved, HCFA should not consider SCHIP enrolled children to be insured and therefore ineligible for free VFC vaccines. Several commenters expressed that States that have elected to implement separate child health programs are being unfairly penalized for not choosing to expand their Medicaid programs.

One commenter indicated that because the SCHIP statute states absolutely that the legislation creates no entitlement, and because the VFC program defines insurance as benefits to which an individual is entitled, it would appear to be clear that, despite their eligibility for SCHIP, children in separate child health programs are not entitled to insurance and thus should be considered VFC-eligible. One commenter also stated that having seen polio epidemics and iron lung machines, HCFA should be working to reduce barriers that prevent many children from getting vaccinated so that epidemic childhood diseases do not become more prevalent in the United States as they are in other countries. One commenter believed that the interpretation of section 316 of the Public Health Service Act, which is used to support the policy that separate child health programs are not eligible to participate in VFC, is overly strict and does not align with the intent of the Act to insure that children receive necessary immunizations.

Response: We agree with the commenter that the intent of the statute is that all children should receive necessary immunizations, and therefore require at § 457.410(b)(2) that all States with separate child health programs provide coverage for immunizations in accordance with the recommendations of the ACIP. We disagree with the commenters only as to whether the VFC program or SCHIP funds cover the cost of required immunizations. We disagree that the VFC program allows payment for immunizations provided to a child enrolled in a separate child health plan.

As explained in a letter to State Health Officials of May 11, 1998, section 1928(b)(2) of the Act defines a "Federally vaccine-eligible child" or a child who is entitled to free Federal vaccines under the VFC program, as "a Medicaid-eligible child, * * * a child who is not insured, * * * a child who is (1) administered a qualified pediatric vaccine by a Federally-qualified health center * * * or a rural health clinic * * * and (2) is not insured with respect to the vaccine, [or] a child who is an Indian * * *." The law further defines the term "insured" as a child " * * * enrolled under, and entitled to benefits under, a health insurance policy or plan, including a group health plan, a prepaid health plan, or an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 * * *." The distinction between Medicaid coverage and other coverage is created by the VFC statute. Under the SCHIP statute, it is clear that children who are enrolled in a separate child health program must not be Medicaid-eligible, as explained in § 457.310(b)(2) of these regulations. They are enrolled under, and entitled to benefits under, a health insurance policy or plan within the definition in section 1928 (b)(2)(B)(ii), as explained above, and their insurance covers the cost of vaccines. Although there is no Federal entitlement to SCHIP coverage, a child who is enrolled in a SCHIP-funded plan is "entitled" to coverage under that plan just as a child enrolled under a group health plan is "entitled" to coverage under the group health plan. Unless they are Indians, children enrolled in SCHIP are not Federally vaccine-eligible under current law. Therefore, the Secretary cannot reconsider her decision on this matter without a change in the law that would define a child enrolled in a separate child health program as a Federally vaccine-eligible child.

Comment: One commenter indicated that it appears that the exclusion of SCHIP children from the VFC program would cause the SCHIP program to be less cost effective than the Medicaid program. The commenter asked if this policy means that States may use this provision as a cost offset in discussions of the revenue neutrality of the SCHIP program design. The Federal government, by design, assures that the SCHIP program will be more expensive in that it must pay for a service that is free under Medicaid.

Response: We do not understand the intent of this comment, as the concept of budget neutrality does not apply to the SCHIP program design. While immunizations are required to be

covered under a separate child health plan, States have discretion to determine what other services will be provided under their State plans, and the amount, scope, and duration of those services.

Comment: One commenter noted that it is crucial that any expansion of health care services in State plans include coverage for essential oral health care benefits. Historically, the number of dentists participating in State Medicaid programs is low. This low participation has prevented most poor children from developing good oral hygiene habits. SCHIP allows States to include oral health care services in their State plans and the commenter urged HCFA to consider this as an important component of increasing the overall health of America's rural children as the agency reviews State plans.

Response: We agree with the commenter that oral health is an integral part of the overall health of children and have engaged in a serious effort to promote oral health, as described earlier in a response to comments on this subpart. However, we do not have the statutory authority to require that States provide any specific services under their SCHIP plans other than those required under sections 2102(a)(7)(A) and 2103(c) of the Act. Although we do not have the authority to require the inclusion of these services, because of the importance of oral health services for children, we have included in the definition of well-baby and well-child care, for purposes of cost-sharing restrictions at § 457.520(b)(5), routine and preventive and diagnostic dental services. Accordingly, a separate child health plan may not impose copayments, deductibles, coinsurance or other cost-sharing for these services. Nonetheless, all but two States with separate child health programs have opted to provide coverage for some type of oral health services.

Comment: One commenter recommended that the regulation clarify that children enrolled under a Medicaid expansion program are entitled to all medically necessary services to the same extent as under the Medicaid EPSDT service and that the services for these children would not be considered a State option.

Response: The regulation indicates in § 457.401(c) that the information in this subpart does not apply to Medicaid expansion programs. Therefore, because this subpart addresses only provisions regarding separate children's health insurance programs, we have not added additional language to the regulation text to indicate that children enrolled under Medicaid expansion programs are

eligible for Medicaid's EPSDT services. However, as we have made clear in the preamble to the proposed regulation and in other guidance, all Medicaid benefit rules, including rules requiring EPSDT services, apply fully to children enrolled in Medicaid expansion programs.

Comment: One commenter noted that the Medicaid program includes coverage for children with serious and severe mental illnesses. The commenter urged HCFA to collaborate with those States opting to develop separate child health programs to provide health coverage for the same level of treatment and service currently provided by Medicaid. Another commenter noted the importance of behavioral health as an integral part of a child's overall well being. According to this commenter, while rural families and children suffer mental disorders similar to those suffered by their urban counterparts, rural residents are less likely to receive treatment in part because of the extreme lack of behavioral health professionals in rural communities. The commenter strongly supported inclusion of coverage for mental health services in the State plans for the SCHIP program.

Response: We agree that mental health is an integral part of the overall health of a child and we urge States to consider providing these services. However, a requirement that States include any specific services in their State plans other than those required under 2102(a)(7)(A) and 2103(c) of the Act and specified under § 457.410(b) would be inconsistent with title XXI.

Comment: One commenter asked why the discussion of § 457.410(b) in the preamble to the proposed regulation about offering different health benefits coverage for children with special needs refers only to children with physical disabilities, and not mental disabilities. Such children may be encompassed within the category of special needs, but the additional listing only of physical disabilities gives the false impression that disability cannot be mental as well.

Response: We did not intend to exclude any type of illness, physical or mental, by using the example of children with physical disabilities in discussing the States' option to offer different health benefits coverage. The preamble noted that States can have more than one benefit package that meets the requirements of the subpart, including one designed for children with special needs or physical disabilities. We were simply giving one example of a population to which States may want to consider offering additional services or a special package of services and did not mean to offer the

example as the only option. States should consider the needs of children with mental disabilities as they consider whether to adopt benefit packages designed specifically for children with special needs.

Comment: One commenter supported the preamble language to proposed § 457.410, which indicates that States can include in their comprehensive health benefits package "supplemental services for children with special needs or physical disabilities" and alternatively may offer multiple benefit packages. Such an approach permits States to expand services to children with special health care needs without regard to the 10 percent cap on Federally-matchable expenditures "for other than the comprehensive services packages." The commenter supported this approach to increasing States' ability to help such children.

However, numerous commenters were concerned with this language in the preamble to proposed § 457.410. Several commenters expressed concern about the language in the proposed rule stating that if a State offers a supplemental package of limited services for children with special health care needs that is not part of the comprehensive coverage required by the regulation, then expenditures for those extra services would be counted against the 10 percent cap on administrative expenses under section 2105(c)(2) of the Act. They noted that a number of States have implemented SCHIP with supplemental benefits packages, or "wrap-around packages", for coverage of services for eligible children with special health care needs and that this is an important, appropriate and beneficial strategy for the provision of needed health care services for children. They indicated that requiring that expenditures for services for children with special health care needs count against the 10 percent cap would encourage States to limit the services that are offered to these children, which could affect their overall health and well being. The commenters argued very strongly that services for children with special health care needs that are provided through an additional limited benefits package should not be counted against the 10 percent cap, and that making them subject to the cap has the potential to discourage the development of creative benefit packages for children with special needs.

Two commenters questioned whether the Department intended to indicate that such initiatives are subject to the 10 percent administrative cap as section 2105(a)(2) makes no mention of special needs. The commenters recommended

that the preamble be modified by dropping the reference to special needs since this reference may be misconstrued when States are designing and implementing certain benefit packages for special needs children. The commenters indicated that the statute contemplates that there are permissible health initiatives which would be subject to the 10 percent cap and suggested that this section of the preamble be written to identify the types of initiatives subject to the limitation without calling into question those benefits packages for children not subject to the 10 percent cap.

One commenter cautioned States about the manner in which they define children with special health care needs. The commenter provided suggested language that States should be encouraged to use to define children with special health care needs.

One commenter believed that the explanation of required coverage in the preamble to the proposed rule forces States either to provide a comprehensive benefit package that is above and beyond the needs of the "average" child in order to ensure that the needs of special needs children are met, or to put administrative dollars at risk. By providing such a comprehensive benefit package, the capitated rate paid to health plans to pay for such services will significantly increase.

One commenter also noted that while the rules permit separate packages of services consistent with the ADA, the 10 percent cap is troubling and it is unclear what the potential impact will be or if this could penalize children and their families in unexpected ways.

Response: Unfortunately, the language in the preamble to the proposed rule about the application of the 10 percent administrative cap in connection with supplemental services for children with special needs caused much confusion to commenters. We will attempt to clarify below.

Under section 2105(a)(1), States may receive enhanced FMAP for expenditures for child health assistance for targeted low-income children provided in the form of health benefits coverage that meets the requirements of section 2103 of the Act. Under section 2105(a)(2) States may receive payment of a federal share of State expenditures for other items but expenditures for these other items are subject to the 10 percent administrative cap under section 2105(c)(2). A State has two options for providing more health benefits coverage to special needs children under which the expenditures for the coverage are not subject to the 10

percent cap on administrative expenditures. The first option would be for the State to have a separate eligibility group for the identified special needs children with a larger health benefits package than for other eligibility groups. The State would have to design the eligibility group without violating the statutory requirement under section 2102(b)(1)(a) of the Act that the eligibility standards "not discriminate on the basis of diagnosis." The second option would be for the State to retain the general eligibility group that includes all children and include in the health benefits coverage package coverage for services needed by special needs children. The package could include limitations for coverage on these services (consistent with other benefits requirements) to ensure that they would be available primarily to special needs children. Under either option, the special needs coverage is part of an overall health benefits coverage package that is consistent with section 2103 of the Act and § 457.410 of the final regulation.

One key aspect of section 2105(a)(2) is that SCHIP funds can be used for health services initiatives for targeted low-income children as well as other low-income children. With respect to the suggestion that we include some examples of public health initiatives that would be subject to the 10 percent cap, we are including the following examples, some of which were proposed by one State: (1) access to mental health services for low-income children in the Juvenile Court System; (2) health care outreach and services for homeless children and adolescents; (3) mental health services for low-income children with special needs; (4) dental care for low-income children and their families; (5) health care services for migrant children; and (6) an immunization project for low-income children who are not enrolled in Medicaid or SCHIP. As we indicated, these are just a few examples for use of title XXI funds for public health initiatives as authorized by section 2105(a)(2) of the Act. States are free to develop and propose initiatives which are specific to the needs of their population.

Comment: One commenter noted that it was pleased that we have included a reference to Bright Futures in the proposed rule but encouraged that we use the term "well-adolescent" whenever we refer to "well-child" and the term "age" when offering examples of diverse populations.

Response: Under the definition of "child" set forth in section 2110(c)(1) of the Act, and implemented in § 457.10 of this final regulation, "child" is an

"individual under the age of 19." An adolescent clearly fits within this definition of child, and therefore we have not accepted the commenter's suggestion to use the term "well-adolescent" whenever we refer to well-child care. In addition, as we explained above, we did not intend to exclude any particular group or condition in describing a special population that States may want to consider offering additional services or a special package of services. Therefore, we have not added "age" to the example we used in the preamble.

Comment: One commenter indicated that there are various ways for separate child health programs to make health benefits coverage available to enrolled children. States may use direct, fee-for-service coverage or can operate as primary care case managers. Separate child health programs can also buy benchmark or benchmark-equivalent coverage provided through an MCE. The commenter went on to say that what is listed as a class of covered benefits in the State plan may not be precisely what is covered if the State chooses to offer coverage solely through a benchmark or benchmark-equivalent package that is purchased from a participating insurer or MCE. Furthermore, the insurer or MCE may apply limits to coverage that would not apply if the coverage were obtained directly through the State-based plan. Finally, the proposed rules on coverage do not require any particular standard for the measurement of medical necessity for children, either by the State or by benchmark insurers.

According to the commenter, because the benchmark plans may differ from the State comprehensive package and no specific medical necessity standard is required for separate child health programs, the issue of disclosure of coverage and coverage limitations becomes important. Both providers and families will need to have clear, understandable materials and information regarding what is and is not covered, as well as the limitations that apply to covered benefits. The commenter cautioned that benchmark plans may not be appropriately designed for children; for example, the plan may provide coverage for speech therapy after a stroke but no coverage for speech therapy to address developmental delays. There is nothing in the proposed rule that requires benchmark plans to be designed to meet the specific health needs of children.

Response: In order for a State plan to be approved, the State must indicate what type of health benefits coverage it is electing to provide. The State must make available to enrollees the full

coverage package defined in its State plan, and may not permit contractors to restrict that coverage. While neither the State nor a contractor is required to furnish medically unnecessary services, they cannot alter the basic coverage package from that specified in the State plan.

Because SCHIP is targeted for children under the age of 19, States must ensure that the health benefits coverage it elects to provide is appropriate for the population being served. The statute addresses the issue of appropriateness of coverage through the coverage requirements at section 2103 of the Act, which sets forth the required scope of health insurance coverage under a separate child health program. In addition, based on the authority of section 2102(a)(7) of the Act, we have required coverage for well-baby and well-child care, immunizations and emergency services. Finally, if a State elects to use benchmark-equivalent coverage, it must cover specific services listed at section 2103(c)(1) of the Act and be actuarially equivalent for additional services covered under one of the benchmark benefit packages. While we have not defined medical necessity for purposes of separate child health programs, we believe that the requirements of the statute and final regulations ensure the appropriateness of coverage for children in separate child health programs.

With respect to the commenter's concerns regarding the availability of understandable materials, we refer the commenter to the requirements at § 457.110(b) and § 457.525 which discuss the requirements for making certain information available and for information on the public schedule for cost sharing.

Comment: Several commenters agreed with HCFA's suggestion in the preamble to proposed § 457.410 that SCHIP programs use the AAP guidelines and/or Bright Futures periodicity schedules. However, they did not agree with HCFA's reasoning for not requiring States to adopt this definition of well-baby and well-child for benefit coverage. One commenter indicated that Medicaid guarantees children coverage of medically necessary services through EPSDT, while separate child health programs do not provide the same guarantee. It is therefore more critical and appropriate for HCFA to place specific requirements on the provision of services because there is no underlying entitlement, and HCFA should establish an appropriate floor. Another commenter indicated that because Medicaid uses the EPSDT standard for its schedule of periodicity,

the schedule should be included for SCHIP coverage to be consistent and allow parity. Rather than merely recommending periodicity schedules, HCFA should require that an endorsed professional standard be adopted by SCHIP programs. Allowing States to devise their own schedules could leave children in different States with widely different coverage under SCHIP.

Response: For a number of reasons, we are not requiring States to use for coverage and other purposes the definition of well-baby and well-child care that is required for purposes of cost sharing. Specifically, HCFA wanted to assure States the flexibility accorded them under the statute in developing their SCHIP benefit packages, including their well-baby and well-child care packages. In addition, there are several expert groups that have developed professional standards for the delivery of well-baby and well-child care. These standards include those developed by the AAP, AAPD and the Bright Futures standards. HCFA has not endorsed any particular professional standard for well-baby and well-child care for Medicaid and we did not feel we should impose a more stringent standard on SCHIP plans. We have included a definition of well-baby and well-child care for purposes of cost sharing because Congress established basic rules for cost sharing that must be applied on a consistent basis across States.

The commenter is correct that under the Medicaid program, EPSDT services are mandatory for most Medicaid eligible children under the age of 21. However, the SCHIP statute did not require this comprehensive service package for children in separate child health programs but rather gave States the flexibility to design their own benefit packages within certain parameters.

With respect to the use of a specific periodicity schedule, the commenter is incorrect that EPSDT services require any specific periodicity schedule. HCFA cannot, by law, require States to use any particular periodicity schedule for the delivery of EPSDT services under Medicaid. The EPSDT statute at section 1905(r) specifies that each State must develop its own periodicity schedule for screening, vision, hearing and dental services after appropriate consultations with medical and dental organizations involved in child health care. In the proposed rule, we suggested that States use one of the professional standards already developed in determining their well-baby and well-child care benefit packages; however, we have declined to require the use of a specific schedule. There are several professional standards

that are acceptable for States to adopt. In fact, many States have adopted one of those standards for use in their EPSDT programs also. This policy does present the possibility, as the commenter suggests, that children may be treated differently in different States. However, this is allowable under title XXI.

Comment: One commenter believed that States should be able to retain discretion to define well-baby and well-child care more broadly than § 457.520 and that HCFA should require States to follow the AAP and Bright Futures periodicity schedules in both Medicaid and SCHIP programs. In particular, many States have not yet adopted a periodicity schedule providing for annual health assessments for adolescents, even though there is consensus among the professional community that adolescents should receive annual assessments.

Response: If a State chooses to define well-baby and well-child care more broadly than defined in § 457.520 for cost sharing purposes in order to limit cost sharing for a broader range of services, the State is free to do so. It is true that some States have not adopted periodicity schedules to allow for annual assessment of adolescents under their Medicaid program. While both programs allow for that flexibility in adopting periodicity schedules, HCFA encourages States to ensure that their periodicity schedules reflect current professional standards.

Comment: One commenter recommended that the AMA's Guidelines for Adolescent Preventive Services (GAPS) be added to the list of appropriate standards for States to consider.

Response: We agree that GAPS is an appropriate standard for States to use in defining well-child care periodicity schedules for adolescents and recommend that States consider this standard as well.

Comment: One commenter reiterated that the preamble language indicates that well-baby and well-child care includes health care for adolescents and is subject to the cost-sharing prohibitions, but is ambiguous as to whether a State has to provide coverage for these services or merely apply the cost-sharing prohibitions to those services that they cover. The commenter believed that States should be required to provide such coverage. The commenter also urged HCFA to add language to the preamble encouraging States to consider the special problems that affect adolescents (for example, eating disorders) when defining special needs.

Response: We appreciate the commenter's concern about adolescents. States are required to provide coverage for well-baby and well-child care services under any separate child health plan but may specifically define those services as they choose. We note that we have revised § 457.410(b)(1) to provide that the State must obtain well-baby and well-child care services as defined by the coverage for the State. Cost sharing is not allowed for any services covered under a separate child health program that are included in the definition of well-baby and well-child care at § 457.520. We have not included language encouraging States to consider special problems that affect adolescents when defining special needs. However, we urge States to consider the special needs of the population being served by the separate child health plan.

Comment: One commenter recommended § 475.410(b) be deleted because the statute provides States with the flexibility to adopt a benchmark plan or to develop an actuarially equivalent benefit package.

Response: We have not adopted this suggestion. The commenter correctly notes that the SCHIP statute provides States with flexibility to adopt benchmark health benefits coverage or actuarially equivalent benefit-equivalent health benefits coverage when designing their programs. However, in accordance with section 2102(a)(7), § 457.410(b) ensures that enrollees in separate child health programs receive coverage for certain basic services.

4. Benchmark Health Benefits Coverage (§ 457.420)

Section 2103(b) of the Act sets forth the benchmark health benefits coverage from which a State may choose in accordance with section 2103(a)(1) of the Act. We proposed to implement these statutory provisions at § 457.420. We proposed to define benchmark health benefits coverage as health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit packages:

- The Federal Employee Health Benefits Program (FEHBP) Blue Cross/Blue Shield Standard Option Service Benefit Plan with Preferred Provider arrangements;
- A health benefits plan that the State offers and makes generally available to its own employees; or
- A plan offered by a Health Maintenance Organization (HMO) that has the largest insured commercial, non-Medicaid enrollment of any such plan in the State.

We discussed each option for benchmark health benefits coverage in

detail in the preamble of the proposed rule. We noted that when a State chooses to increase, decrease, or substitute coverage available under its approved State plan, a State must submit a State plan amendment for approval if the change in benefits is intended to conform the separate State benefit package to the benchmark coverage. But if the change in benefits causes the State offered benefits to differ from the benchmark coverage, then the benefits must be reclassified as benchmark equivalent or one of the other benefit package options.

We also noted that section 2103(a)(1) of the Act provides that benchmark coverage must be "equivalent" to the benefits coverage in a reference benchmark benefit package. We stated that we would interpret this language to mean that coverage must be "substantially equal" to benchmark coverage. That is, benchmark coverage offered under a separate child health plan should differ from benchmark coverage available in the State only to the extent that the State must add coverage to the benchmark coverage, such as coverage for immunizations, to meet the requirements of title XXI.

Comment: Numerous commenters had requested clarification of when a State plan amendment is required if a benchmark plan changes. These commenters interpreted the language at § 457.20 of the proposed rule to mean that if the benchmark plan the State is using changes, we would not require a State plan amendment; whereas if the State chooses to change the coverage under its State plan to conform to the benchmark plan's changes, a plan amendment would be required. The commenters asked why changes to a State plan that simply parallel changes in a benchmark plan require an amendment given that benchmark plans are supposed to be the standard of adequacy in terms of SCHIP benefits.

Several commenters believed the preamble should be clarified to indicate that an amendment is only required when the SCHIP benefits package is altered.

Response: The approved State plan must accurately reflect the health benefits package being offered. A State must submit a State plan amendment to reflect any change in the health benefits coverage regardless of whether the change is made to conform to changes made in the benchmark plan to which the State's health benefits coverage is supposed to be equivalent, or whether the change is made to select a different health benefits coverage option. See subpart A for further discussion of when

a State must submit a State plan amendment.

Comment: One commenter felt that States should not be allowed to amend their State plans to make them less comprehensive in terms of coverage or the benefits they provide. According to this commenter, State plans should only be amended to improve coverage, not to diminish it. A basic package of benefits should be required. In other words, certain benefits should be Federal entitlements. States then have the flexibility to improve that benefit package or to offer only what is Federally required.

Response: States are responsible for determining the health benefits coverage under a separate child health program subject to the standards set by title XXI and implemented in this final regulation. States have the option of choosing from the types of coverage specified in § 457.410 of the proposed rule and in accordance with section 2103 of the Act. States may amend their State plans to decrease the coverage provided as long as all of the requirements of §§ 457.410–457.490 are met, depending on the type of coverage approved in the State plan. The only services required to be covered under every separate child health program are well-baby and well-child care, immunizations according the ACIP schedule, and emergency services as defined in § 457.10.

Comment: One commenter was concerned that a State that is using the benchmark benefit package need not submit an amendment when the benchmark changes and believed this means that if the plan includes mental health services that are subsequently dropped, the State need not file a State plan amendment.

Response: If a State has elected to provide benchmark health benefits coverage that is substantially equal to coverage under a certain benefit plan, and that plan drops coverage for mental health services, the State has two options. First, the State may continue to provide coverage for mental health services as described in its approved State plan, even though the benchmark plan has discontinued this coverage. No amendment is necessary in this case. Alternatively, if the State wants to discontinue providing mental health services under its State plan, it must submit a State plan amendment to reflect the dropped coverage.

Comment: One commenter supported the preamble language on benchmark coverage being able to differ from coverage under a benchmark plan only as necessary to meet other requirements of title XXI.

Response: We appreciate the support. The commenter is correct that benchmark health benefits coverage under § 457.420 may only differ from coverage under the benchmark plan as necessary to meet title XXI requirements. For example, as noted earlier, a State may need to add coverage for immunizations in order to comply with the requirement that they be covered under every separate child health plan.

Comment: One commenter stated that the preamble indicates in discussing § 457.420(c) that “in calculating commercial enrollment, neither Medicaid nor public agency enrollees will be counted.” The commenter suggested that all public agency enrollees be counted as commercial enrollees when they are enrolled in a plan offered by a private sector HMO. If it is appropriate to count Federal employees as commercial enrollees, it should be just as appropriate to count any other public employees who are enrolled in the plan. Another commenter recommended that § 457.420(c) be modified to be consistent with the preamble to exclude public agency enrollees. The proposed regulation only excludes Medicaid enrollees.

Response: We agree with the comments noting that the preamble and regulation text were not consistent with respect to the calculation of commercial enrollment. We also recognize, as noted by one of the commenters, that the preamble statement that Federal employees are considered commercial enrollees, but public agency enrollees are not, merits further consideration.

After further consideration, we have decided to retain the regulatory language as proposed, that is, the health insurance coverage plan that is offered through an HMO and has the largest insured commercial, non-Medicaid enrollment in the State. Public agency employees, as well as Federal employees, may be considered enrollees for purposes of calculating commercial enrollment.

5. Benchmark-Equivalent Health Benefits Coverage (§ 457.430)

Section 2103(a)(2) of the Act provides that a State may opt to provide a benefits package with an aggregate actuarial value that is at least equal to the value of one of the benchmark benefit packages. In accordance with the statute, we proposed at § 457.430 that the benchmark-equivalent coverage must have an aggregate actuarial value, determined in accordance with proposed § 457.431, that is at least actuarially equivalent to coverage under

one of the benchmark packages outlined in § 457.420.

In § 457.430 we set forth the proposed coverage requirements for States selecting the benchmark-equivalent coverage option. Under the authority of section 2103(c)(1), we proposed that a benchmark equivalent plan must include coverage for inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age-appropriate immunizations provided in accordance with the recommendations of ACIP.

Under the authority of section 2110(a) of the Act as implemented at proposed § 457.402, a State may provide coverage for a wide range of services. Under the authority of section 2103(a)(2)(C), we proposed that if the State provides coverage for prescription drugs, mental health services, vision services, or hearing services, the coverage for these services must have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of service in the benchmark benefit package. In addition, we proposed that if the benchmark plan does not cover one of the above additional categories of services, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service. A State may provide services listed in § 457.402 other than the services listed in § 457.430(b) without meeting the 75 percent actuarial value test.

Comment: Two commenters believed § 457.430 is ambiguous, confusing and potentially troublesome and allows for a court to read some distinction into the redundant provisions at 457.410(b)(1) and (2) and 457.430(b)(4) about well-baby and well-child care and immunizations applying only to benchmark-equivalent coverage. To avoid such a result, the commenter suggested that HCFA strike § 457.430(b)(4) and revise subsection (b) to read as follows: “(b) Required services. Benchmark equivalent health benefits coverage must include, in addition to the services described in § 457.410(b), coverage for the following categories of service.”

Response: We have accepted the commenter's suggestion to revise proposed § 457.430. We have also revised § 457.410(b)(2) of the regulation text to add the phrase “age appropriate” to immunizations in order to make it consistent with proposed § 457.430(b)(4).

Comment: One commenter is concerned because mental health

services do not fall within the scope of required services under SCHIP. The commenter is particularly concerned that children in a State that initially use a Medicaid-expansion program and then move to a separate child health program will lose the EPSDT safety net for mental health services.

Response: While children receiving SCHIP services under a Medicaid-expansion program are required to be provided the full complement of EPSDT services, there is no such requirement under a separate child health program. It is true that some children with coverage for mental health services under a Medicaid expansion could lose that coverage if the State decided to switch to a separate child health program. Those children, however, would be in no worse position than if the State had originally elected a separate child health program. We have no basis to limit State flexibility by mandating benefits beyond those specifically required by the statute, however, we encourage States electing to shift from a Medicaid expansion program to a separate child health program or combination program to retain a comprehensive benefits package that is similar to the Medicaid expansion benefit package to help ensure that children do not experience a significant disruption in care.

Comment: One commenter believed HCFA should promulgate minimum benefits standards for benchmark-equivalent coverage. They noted that HCFA indicated that it has chosen not to propose minimum standards for basic sets of services because a greatly reduced benefits schedule would be unlikely to meet actuarial value requirements. However, the commenter argues that because SCHIP plans may involve much lower cost-sharing requirements than commercial plans, a SCHIP benefits package can offer far fewer services than a benchmark commercial plan and still pass actuarial muster. Accordingly, the commenter respectfully urged the Secretary to revisit this decision and promulgate minimum benefits standards for benchmark-equivalent coverage.

Response: We have considered the issue raised by the commenter but have declined to revise the regulation to set minimum standards at this time. The actuarial value requirements should ensure that the benefits in an actuarial-equivalent benefit package that will not fall below levels intended by title XXI. In fact, experience has shown that States that have chosen to provide benchmark-equivalent health benefits coverage provide coverage that looks very similar

to coverage under other health benefits coverage options.

Comment: One commenter recommended deleting § 457.430(c)(2) because benchmark-equivalent coverage should not be required to include coverage for specific services just because they are covered in the benchmark package. According to this commenter, the intent of equivalent packages is to allow a State the flexibility to design coverage that meets the needs of children in the state.

Response: The language in § 457.430(c)(2) mirrors section 2103(a)(2)(C) of the Act. Therefore, we have not adopted the commenter's suggestion to delete this material.

6. Actuarial Report for Benchmark-Equivalent Coverage (§ 457.431)

In accordance with section 2103(c)(4) of the Act, at § 457.431 we proposed to require a State, as a condition of approval of benchmark-equivalent coverage, to provide an actuarial report, with an actuarial opinion that the benchmark-equivalent coverage meets the actuarial requirements of § 457.430. We also proposed that the actuarial report must specify the benchmark coverage used for comparison.

The actuarial opinion must meet all the provisions of the statute. We proposed that the report must explicitly state the following information:

- The actuary issuing the opinion is a member of the American Academy of Actuaries (and meets Academy standards for issuing such an opinion).
- The actuary used generally accepted actuarial principles and methodologies of the American Academy of Actuaries, standard utilization and price factors, and a standardized population representative of privately insured children of the age of those expected to be covered under the State plan.
- The same principles and factors were used in analyzing both the proposed benchmark-equivalent coverage and the benchmark coverage, without taking into account differences in coverage based on the method of delivery or means of cost control or utilization used.
- The report should also state if the analysis took into account the State's ability to reduce benefits because of the increase in actuarial value due to limitations on cost sharing in SCHIP.

Finally, we proposed that the State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by HCFA, to replicate the State's result.

Comment: We received two comments on this section. One commenter supported the requirement for a set of comprehensive actuarial reports. The second commenter suggested that the requirement for proof of actuarial equivalence of the benefits will be too costly. The commenter noted that insurance industry and State regulatory departments have developed methods of comparing coverage that would be significantly more cost effective and equally as useful for the program as an actuarial study.

Response: We appreciate the support of the first commenter. In response to the suggestion of the second commenter, the actuarial report requirements contained in this section of the regulation text are basically drawn from the section 2103(c)(4) of the Act. Therefore, we have chosen not to alter the requirements in the regulation to allow an alternative approach to benchmark equivalent coverage. However, as discussed under § 457.450, we are willing to entertain other suggestions for Secretary-approved coverage. We will consider States' specific proposals for alternatives to actuarial analysis under the provisions of § 457.450.

7. Existing Comprehensive State-Based Coverage (§ 457.440)

In accordance with section 2103(d) of the Act, at § 457.440 we proposed that existing comprehensive State-based health benefits coverage must include coverage of a range of benefits, be administered or overseen by the State and receive funds from the State, be offered in the State of New York, Florida, or Pennsylvania, and have been offered as of August 5, 1997. In essence, Congress deemed the existing State-based health benefit packages of three States as meeting the requirements of section 2103 of the Act. We noted that these States still need to meet other requirements of title XXI, including requirements relating to cost sharing, such as copayments, deductibles and premiums, as specified in subpart E of this final rule.

We also proposed that the States (Florida, New York, and Pennsylvania) may modify their existing, comprehensive, State-based program under certain conditions. First, the program must continue to offer a range of benefits. Second, the modification must not reduce the actuarial value of the coverage available under the program below either the actuarial value of the coverage as of August 5, 1997 or the actuarial value of a benchmark benefit package. A State must submit an

actuarial report when it amends its existing State-based coverage.

We did not receive any comments on this section. Therefore, we are implementing these provisions as set forth in the proposed rule except that we have added language to the regulation to clarify that a State must submit an actuarial report when it amends its existing State-based coverage.

8. Secretary-Approved Coverage (§ 457.450)

Section 2103(a)(4) of the Act defines Secretary-approved coverage as any other health benefits coverage that provides appropriate coverage for the population of targeted low-income children to be covered by the program. In proposed § 457.450 we set forth the option of providing health benefits coverage under the Secretary-approved health benefits coverage option.

We proposed that the following coverage be recognized as Secretary-approved coverage under a separate child health program:

- Coverage that is the same as the coverage provided under a State's Medicaid benefit package as described in the existing Medicaid State plan.
- Comprehensive coverage offered under a § 1115 waiver that either includes coverage for the full EPSDT benefit or that the State has extended to the entire Medicaid population in the State.
- Coverage that includes benchmark coverage, as specified in § 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that it provides all the benchmark coverage, including all coverage required under title XXI, but may also provide additional services.
- Coverage, including coverage under a group health plan, purchased by the State that the State demonstrates to be substantially equal to coverage under one of the benchmark plans specified in § 457.420, through use of a benefit-by-benefit comparison of the coverage. Under this option, if coverage for just one benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in § 457.431 to determine actuarial equivalence.

While we listed these four options as permissible types of Secretarial-approved coverage, we solicited comments on other specific examples of coverage packages that States have developed, or might wish to develop, to meet the Title XXI requirements. We also proposed that no actuarial analysis is required for Secretary-approved

coverage if the State can show that the proposed benefit package meets or exceeds the benchmark coverage. While the four options we listed meet or exceed the benchmark package, it is possible that a State may develop a Secretary-approved coverage proposal that may require an actuarial analysis.

Comment: One commenter argued that "Secretary-approved coverage" should provide HCFA with greater flexibility to approve SCHIP State plans. The commenter points out that Secretary-approved coverage is not simply another name for benchmark coverage; title XXI provides for Secretary-approved coverage as a flexible way for HCFA to approve a State plan. The statute requires no actuarial analysis for this option but rather requires only that the coverage be deemed "appropriate" for the target population.

The commenter recommended that the regulations should simply indicate that States must demonstrate, to the Secretary's satisfaction, that their coverage meets the needs of their SCHIP populations. The manner in which States make this demonstration should be left flexible in accordance with the discretion accorded to States by title XXI.

Response: The list of four examples included in the regulation text at § 457.450 was not meant to be an exhaustive list of examples of Secretary-approved coverage. The regulations text states that Secretary-approved coverage "may include" one of these options. We solicited additional examples of types of coverage that might qualify under this option but we did not receive any specific examples. We remain open to reviewing other proposals for Secretary-approved coverage.

Comment: One commenter noted that a number of States are exploring buy-in programs where SCHIP funds will be used to subsidize coverage for the uninsured under group health plans. A significant issue for States is how to design programs that can meet HCFA's SCHIP benefit requirements. The preamble to the proposed rule states that if any benefit under an employer plan does not meet or exceed that of a benchmark plan provided under title XXI, based on a benefit-to-benefit comparison, the State must document that the two benefit packages are actuarially equivalent. However, providing such comparisons would likely be costly and burdensome to implement on an employer-by-employer basis. The commenter strongly encouraged HCFA to modify the preamble to provide for maximum State flexibility in the area of benefit

certification under buy-in programs. HCFA could provide such flexibility by allowing States more flexibility to designate benefit packages that meet the benchmark standard or to use simple benefit checklists.

Response: We recognize the administrative burden involved in determining whether employer plans meet benefit requirements for separate child health programs, and we agree that documenting the actuarial equivalence of a plan or using benefit side-by-side comparisons may be costly and burdensome. Nonetheless, employer plans through which States wish to offer coverage under a separate child health program must meet requirements for either benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage in order to comply with section 2103 of the Act. However, we are open to, and encourage States to propose other options under the "Secretary-approved" category.

Comment: Two commenters recommended that proposed § 457.450 should explicitly reference Medicaid benefits for children rather than permit States to furnish SCHIP children with Medicaid benefits for adults without any actuarial analysis showing comparability to standard commercial benefits. Specifically, paragraphs (a) and (b) should be consolidated and revised to read: "(a) Coverage that is the same as the coverage for children provided under the Medicaid State plan."

Response: While we have not adopted the exact language and consolidation recommended by the commenter, we have revised § 457.450(a) to specify that coverage should be the same as that offered to children under the Medicaid State plan.

Comment: One commenter believed the proposed rule should be amended to eliminate the use of a benefit-by-benefit comparison for determining whether coverage provided through premium assistance under a group health plan is approvable. This provision appears to require benefit-by-benefit comparison for demonstrating that group health plans meet or exceed coverage requirements. This is a more rigorous test than that required for benchmark equivalent coverage purchased directly by States. Premium assisted group health plan coverage should be held to no more than the requirements for benchmark equivalent coverage.

The commenter noted that their State experience has shown that children are more likely to be insured if their parents are insured and that parents prefer to cover their entire family under the same plan. HCFA's imposition of barriers to

the use of SCHIP programs to support group health coverage is a misguided attempt to address substitution of coverage. States should be given as much flexibility as possible to test different approaches, including buy-in to employer sponsored plans, for increasing creditable coverage for uninsured children. HCFA should not add any restrictions to those already established by law in title XXI.

Response: We did not intend to impose additional restrictions on States wishing to utilize premium assistance programs in SCHIP. The benefit-by-benefit comparison was developed in response to States who wanted to provide premium assistance through employer sponsored insurance but were concerned about the cost of performing the actuarial analysis required by the statute for each participating employer plan. Therefore, we proposed that States may compare each benefit to the benefits in the benchmark plan as a way of providing States with a simplified and lower cost option to the actuarial analysis. However, given the statutory requirement for actuarial equivalence we still require that States perform an actuarial analysis if one benefit is lower than the level specified in the benchmark plan.

9. Prohibited Coverage (§ 457.470)

In accordance with section 2103(c)(5) of the Act, we proposed at § 457.470 that a State is not required to provide health benefits coverage under the plan for an item or service for which payment is prohibited under title XXI even if any benchmark package includes coverage for that item or service. We did not receive any comments on this section. Therefore, we are implementing these provisions as set forth in the proposed rule.

10. Limitations on Coverage: Abortions (§ 457.475)

This section implements sections 2105(c)(1) and (c)(7) of the Act, which set limitations on payment for abortion services under SCHIP. At § 457.475, we proposed that FFP is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services, unless the abortion is necessary to save the life of the mother or the abortion is performed to terminate a pregnancy resulting from an act of rape or incest.

Additionally, we proposed that FFP is not available to a State in expenditures of any amount under its title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other

than to save the life of the mother or resulting from an act of rape or incest.

We also proposed that, if a State wishes to have managed care entities provide abortions in addition to those specified above, those abortions must be provided pursuant to a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate to be paid with State-only funds, or append riders, attachments, or addenda to existing contracts to separate the additional abortion services from the other services covered by the contract. The proposed regulation also specified that this requirement should not be construed as restricting the ability of any managed care provider to offer abortion coverage or the ability of a State or locality to contract separately with a managed care provider for additional abortion coverage using State or local funds.

Comment: One commenter recommended that abortions be covered under any circumstances.

Response: Federal financial participation is available in expenditures for abortions in an SCHIP program only as specifically authorized by Congress in the statute. Section 2105(c)(1) of the Act limits funding of abortions to funding for those abortions necessary to save the life of the mother or to terminate pregnancies resulting from rape or incest.

Comment: We received many comments on the requirement that States that wish to cover abortions other than those allowed under the statute use separate contracts with managed care organizations to ensure that no Federal SCHIP funds are used to pay for those additional abortions. The commenters believed that this requirement exceeds the statutory authority, will be burdensome for States and managed care entities, and may ultimately serve to dissuade States and managed care entities from offering abortion services. Several commenters also indicated that enforcement of the requirement is not feasible in an employer-sponsored insurance environment where the benefits package is predetermined by an employer and a commercial insurer, rather than by the State. They recommended that employer-sponsored programs be exempt from the separate contract requirement.

Response: Section 2105(c)(7) of the Act specifies that "payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that included coverage of abortion." Congressional authorities have made clear that this

section of the statute requires separate contracts where managed care organizations will be providing abortions in addition to those specified in the law. Thus, contrary to the opinion of the commenters, this prohibition can not be satisfied by carving out or allocating a portion of the capitated rate to be paid for with State-only funds.

11. Preexisting Condition Exclusions and Relation to Other Laws (§ 457.480)

In proposed § 457.480 we implemented the provisions of sections 2103(f), and 2109 of the Act under the authority of section 2110(c)(6) we implemented the provisions of sections 2103(f), 2109 and 2110(c)(6). At § 457.480(a), we proposed to implement section 2103(f) of the Act and provide that, subject to the exceptions in paragraph § 457.480(a)(2), a State child health plan may not permit the imposition of any preexisting condition exclusion for covered benefits under the plan. In § 457.480(a)(2), we proposed that if the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as permitted under ERISA and HIPAA.

In proposed § 457.480(b), we implemented sections 2109 and 2103(f)(2) of the Act, which describe the relationship between title XXI and certain other provisions of law. Specifically, as set forth in proposed § 457.480(b), these provisions include section 514 of ERISA, HIPAA, the Mental Health Parity Act of 1996 (MHPA) (regarding parity in the application of annual and lifetime dollar limits to mental health benefits) and the Newborns and Mothers Health Protection Act of 1996 (NMHPA) (regarding requirements for minimum hospital stays for mothers and newborns). See regulations at 45 CFR 146.136 for a discussion of the MHPA and 45 CFR 146.130 and 148.170 for a discussion of the NMHPA.

Comment: One commenter agreed with the inclusion of language in § 457.480 requiring compliance with the Mental Health Parity Act. However, several commenters raised concerns because they interpreted the language at § 457.480(b)(3) and (4) to mean that States must comply with the MHPA and the NMHPA, regardless of whether or not the State's benchmark plan includes these components. The commenters believed this requirement negates the flexibility otherwise provided the State in choosing the option of using a separate child health plan. The

commenters believed that this language should be removed from the final regulation and that States should decide if inclusion of these components in their separate child health programs is appropriate.

One commenter indicated that this requirement would require the offeror of the benchmark plan either to price a SCHIP product separately to the State, to incorporate the mental health parity costs and benefits, or to include these benefits at the same cost (an unlikely scenario). Either way, the commenter argued that the provision reduces the flexibility of using a benchmark plan and thus the proposed linkage of SCHIP to these laws is not appropriate and should be removed.

Response: We agree that the proposed regulation language was unclear and have revised the language to clarify this issue. The commenters appear to have interpreted the proposed rule to mean that States must provide coverage for mental health services and services for newborns and mothers regardless of whether a State's benchmark plan includes coverage for those services. We did not intend to impose such coverage requirements.

The requirements of the MHPA apply only to group health plans (or health insurance coverage offered by issuers in connection with a group health plan) that provide such medical/surgical benefits for newborns and mothers and mental health benefits. Thus, the provisions of MHPA apply only to title XXI coverage provided through a group health plan and only if that plan offers mental health benefits. However, if a State uses a group health plan as a benchmark, then the State may be implicitly required to comply with the MHPA even if that law is not directly applicable. Similarly, the NMHPA applies directly only to group health plans and health insurance issuers (in the group and individual markets) providing benefits for hospital lengths of stay in connection with child birth. We did not intend to impose additional coverage requirements on States or to reduce the State's flexibility in defining its service packages. We have thus revised the regulations to clarify that only group health plans through which States provide coverage under a State plan are subject to the requirements of the provisions described in §§ 457.480(b)(3) and (4).

Comment: One commenter raised the issue of HIPAA requirements and the pre-existing condition exclusions. The commenter noted that because SCHIP enrollees generally will not meet the requirements of "eligible individuals" under HIPAA, the level of protection

afforded by this proposed rule against pre-existing condition exclusion clauses in a SCHIP benchmark package offered by a private insurer is unclear. The proposed rule does state that SCHIP benefits are creditable coverage; however, the commenter stated that the prohibition against pre-existing condition exclusions is triggered only if creditable coverage was followed by COBRA coverage. The commenter noted that clarification of the pre-existing condition exclusion provisions will be important for health providers caring for children with disabilities.

One commenter also indicated that the regulations do not permit any "preexisting conditions exclusions" for a State plan in general. However, if a SCHIP plan provides coverage through a group health plan, the plan could impose preexisting conditions exclusions in accordance with what is allowable under HIPAA. While HIPAA does limit the extent of preexisting condition exclusions, States should be allowed to negotiate with health plans the elimination of all preexisting condition exclusions.

Another commenter encouraged the inclusion of a statement at § 457.480(a)(2) that while States may, in very limited circumstances, permit the imposition of a pre-existing condition exclusion consistent with applicable Federal law, States have the discretion to, and are encouraged to, negotiate group health plan coverage free of such exclusions.

Response: Section 457.480(a) of the regulation implements section 2103(f)(1) of the Act and provides that a State may not permit the imposition of a pre-existing condition exclusion, except in the case of a State that obtains health benefits coverage through payment for, or a contract with, a group health plan or group health insurance coverage, in which case the State may permit the imposition of such an exclusion to the extent permitted under HIPAA. The protection afforded to enrollees is clear; they either face no pre-existing condition exclusion or, if enrolled in a group health plan, they potentially face an exclusion that in no case can be longer than the 12 months permitted under HIPAA. The commenter correctly notes that enrollees in a separate child health program may not meet the definition of "Federally eligible individual" under HIPAA's individual market protections (although they may if their most recent coverage was SCHIP coverage through a group health plan and they then exhausted any COBRA or State continuation coverage offered to them). Presumably, the commenter was concerned about former enrollees

wishing to purchase private, individual market coverage. Title XXI does not provide enrollees with an assurance of meeting the definition of Federally-eligible individuals under HIPAA. However, section 2110(c)(2) of the Act as implemented at § 457.410 provides that coverage meeting the requirements of § 457.10 provided to a targeted low-income child constitutes creditable health coverage. Therefore, coverage under a separate child health program will count towards the minimum 18 months of coverage required for someone to qualify as a Federally-eligible individual.

Comment: One commenter also urged States that do and do not have mental health parity statutes to include coverage for a full range of mental illness services in their State plans when they opt to develop separate child health programs.

Response: States are given flexibility in designing their benefit packages. While we encourage States to provide services for mental illness, there is no Federal requirement for a State to include this coverage under its separate child health program if it does not elect to do so.

Comment: One commenter believed the regulation should include a statement that pre-existing condition exclusions are contrary to the intent of SCHIP and unfair. Therefore, even under the limited circumstances where such exclusions are allowed, States must be required to demonstrate attempts to negotiate group health plan coverage free of such exclusions. According to this commenter, only after demonstrating that those efforts have been exhausted, should a State plan with these very limited exclusions be approved.

One commenter asserted that the HIPAA-allowable conditions for permitting a waiting period for services for a preexisting condition are adverse to the purposes of initiating coverage for children cut off from access to services precisely because they lack coverage. The commenter believed most, if not all, children should be assessed, diagnosed, and treated quickly in response to their health deficiencies. The commenter believed this is a matter for Congress to reconsider.

Response: The language in the proposed rule at § 457.480(a)(1) and (2) was included based on section 2103(f)(1) of the Act. Section 2103(f)(1)(B) clearly provides for the possibility that States providing benefits through group health plans may allow those plans to impose pre-existing condition exclusions to the extent permitted by HIPAA. One limited

exception to this rule is permitted. Under § 2103(f)(1)(B) of Title XXI, if a State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance, the plan may permit the imposition of those preexisting conditions which are permitted under HIPAA. This permits the imposition of preexisting conditions consistent with the requirements of such plans when the State is providing premium assistance through SCHIP to subsidize child or family coverage under a group health plan or group health insurance pursuant to § 2105(c)(3) of the statute. Therefore, we are unable to revise this section as suggested by the commenter.

12. Delivery and Utilization Control Systems (§ 457.490)

In accordance with section 2102(a)(4) of the Act, at § 457.490 we proposed to require that State plans include a description of the type of child health assistance to be provided including the proposed methods of delivery and proposed utilization control systems. In describing the methods of delivery of the child health assistance using title XXI funds, the proposed regulation requires a State to address its choice of financing and the methods for assuring delivery of the insurance product to children including any variations. We also proposed that the State describe utilization control systems designed to ensure that children use only appropriate and medically necessary health care approved by the State or its subcontractor. We set forth examples of utilization control systems in the preamble to the proposed rule.

Comment: One commenter noted that in this section of the proposed rule, HCFA requests a description of utilization controls designed to ensure that children use only appropriate and medically necessary health care, but does not define "medically necessary" in any specific manner. The commenter suggested that this term be defined in the regulation and suggested language to be used in the regulation as a definition of medically necessary.

Response: As we have indicated in response to comments on § 457.420, HCFA will not define medical necessity for SCHIP. The determination of medical necessity criteria for separate child health programs is left up to each State to define.

Comment: One commenter noted that utilization controls that might be appropriate for the adult population may not be appropriate for the pediatric population. As States implement these controls, it is important that they are

appropriate for children. These controls should take into consideration children with special health care needs as well as the unique needs of children in general.

Response: The language in § 457.490(a) of the proposed rule very specifically says “methods for assuring delivery of insurance products to the children.” Section 457.490(b) provides for “systems designed to ensure that children use only appropriate * * *” (emphasis added). We believe this language, along with the language at proposed § 457.735 (now § 457.495) requiring States to assure appropriateness of care, very clearly requires that the utilization controls be appropriate for the pediatric population. If a State provides coverage for services for children with special health care needs, States would be expected to ensure appropriate utilization controls on these services also. We believe the language in paragraph § 457.490(a) requiring States to describe methods to assure delivery of services “including any variations,” is sufficient to address this commenter’s concerns. “Variations” would include additional services delivered to special needs children.

Comment: We received two comments suggesting the addition of default enrollment language in the regulation. One commenter recommended that HCFA adopt language similar to the language in the Medicaid managed care proposed rule to address default enrollment under SCHIP for States that offer eligible children a choice of plans. The commenter suggested that HCFA require that States describe in their plans the policies and procedures that they will use to minimize rates of default enrollment and what efforts the State and its contractors will make to preserve traditional provider-patient relationships. The commenter also recommended that this section include an additional paragraph:

Describe policies and procedures that minimize rates of default enrollment where beneficiaries have a choice of plans, and what efforts have been made by the State and its contractors to preserve existing provider/patient relationships. States must also describe opportunities for beneficiaries to disenroll both for cause or on a periodic basis without cause.

Response: Default enrollment, also referred to as auto assignment, is a practice utilized by several States in their enrollment processes. However, we believe that any information or requirements regarding managed care enrollment procedures, including default enrollment, should be addressed as part of the requirements of § 457.110(a), rather than in this section.

Comment: One commenter supported the language in this section and indicated that this sets out a helpful framework that encourages States to ensure that utilization controls limit costs without denying essential health care to children.

Response: We appreciate the commenter’s support.

Comment: One commenter recommended that § 457.490(a) be modified to be applicable not only to the delivery of the insurance products but also to delivery of services covered by the product.

Response: We have adopted this suggestion and revised the regulation text accordingly.

Comment: Two commenters recommended that this section be modified to require State plans to identify methods the States will use to monitor and evaluate delivery and utilization control systems to ensure that children receive appropriate and medically necessary care.

Response: Proposed § 457.735 (now § 457.495) addresses State plan requirements for assuring quality and appropriateness of care provided under the plan. Please see our responses to comments in that section.

13. *Grievances and Appeals (Proposed § 457.495)*

At § 457.495, we proposed to require States to provide enrollees in a separate child health program with the right to file grievances or appeals for reduction or denial of services in accordance with proposed § 457.985. In an effort to consolidate all provisions related to review processes, we have removed proposed § 457.495 and incorporated those provisions into new subpart K, which contains provisions regarding grievances and appeals. We address comments on proposed § 457.495 in new subpart K.

14. *State Plan Requirement: State Assurance of the Quality and Appropriateness of Care (§ 457.495)*

Sections 2102(a)(7)(A) and (B) of the Act require the State plan to describe the strategy the State has adopted for assuring the quality and appropriateness of care, particularly with respect to providing well-baby care, well-child care and immunizations, and for ensuring access to covered services, including emergency services. We proposed to implement this provision at § 457.735(a), and provided further specifications therein consistent with this statutory requirement.

We also proposed to include additional, more specific assurances designed to ensure the quality and

appropriateness of care for particularly vulnerable enrollees. In § 457.735(b), we proposed that States must provide assurances of appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions, including access to specialists.

In this final rule, we are redesignating the provisions of proposed § 457.735 (which were previously located in subpart G, Strategic planning) as § 457.495. We believed that these provisions are more appropriately presented in the context of this subpart. We respond to all public comments on proposed § 457.735 below.

Comment: We received several comments indicating that this section of the proposed rule was unclear as to whether the requirement for State assurance of quality and appropriateness of care applies to SCHIP coverage provided through employer plans. Commenters indicated that the requirements of the proposed regulation seem tacitly to assume that the State will have a direct, contractual relationship with all SCHIP participating health plans, including employer-sponsored plans. A commenter further stated that any attempt to apply such requirements directly to employer-sponsored plans would mean that no employer plans will ever qualify for the State’s premium assistance under SCHIP, as there is no incentive for an employer or plan to invest resources to comply with these requirements. Commenters indicated that employer-sponsored health coverage systems do not identify individuals who can be classified into such categories as “enrollees with special or complex medical conditions,” making it difficult to report on these subgroups.

Response: We understand the commenters’ concerns and desire that data reporting requirements under SCHIP are able to work within the systems and regulatory structure for premium assistance programs. The provisions of this regulation section do apply to such coverage because the statute contains no exemptions from its reporting requirements for SCHIP coverage offered through premium assistance programs. However, the regulation does not require States to report encounter data in measuring their progress toward meeting performance goals. We encourage States to use a variety of methods to collect appropriate data. While requiring plans to report encounter data to the State is one means of gathering these data, it is by no means the only method. For example, States can rely on mail or telephone surveys of

participating families and surveys of participating providers, or can design a data collection methodology that works with the structure and offerings of their SCHIP programs, including those operating premium assistance programs.

Comment: We received comments recommending that we require specific reporting requirements for States offering premium assistance programs through group health plans.

Response: States that implement or design premium assistance programs for SCHIP have flexibility to explore different methods of working with employers, health plans and beneficiaries to obtain information on SCHIP coverage provided through group health plans. Because of the difficulty of obtaining data from employer plans with which the State may not have direct contractual relationships, we intend to continue to work with States exploring the implementation of premium assistance programs and will continue to consider a variety of State proposals regarding appropriate methods of obtaining information about the quality of care obtained through premium assistance programs.

Comment: We received comments that the regulation should allow States the flexibility to use strategies that employers already have in place, or to use alternative strategies, to ensure quality and appropriateness of care.

Response: First, it should be noted that, upon further reflection, we have determined that the provisions and intent of proposed § 457.735 would fit more appropriately within Subpart D, Benefits. The focus of this provision is to ensure that SCHIP enrollees have adequate access to health care services as needed. Therefore, we have moved the comments and responses on this provision to Subpart D, § 457.495.

We agree that, pursuant to the provisions of title XXI, States should have the flexibility to use innovative strategies to ensure quality and appropriateness of care. Section 457.495(a) provides that States must provide HCFA with a description of the methods that a State uses for assuring the quality and appropriateness of care provided under the plan. We did not specify a particular method States must use to monitor appropriateness and quality of care. We anticipate that States will use a variety of methods, including those most suitable for the type of program or programs a particular State is implementing.

Comment: Several commenters recommended that we establish specific, unified, quality and access standards with respect to those areas set forth in § 457.495 and identify the

methodologies for monitoring those standards in the regulations. Several commenters recommended that we require States to describe methods they will use to ensure that children have access to pediatricians and other health care providers with expertise in meeting the health care needs of children. The commenters felt that physicians who are appropriately educated in the unique physical and developmental issues surrounding the care of infants, children, young adults and adolescents should provide children's care. As the SCHIP program is specifically designed to serve children, commenters noted that it is critical that access to appropriate providers of care be required. One commenter recommended the annual application of a standardized survey of children's mental, physical, and social health.

Response: Section 457.495 requires that a State describe the specific elements of its quality assurance strategies. These may include the use of any of the following methods: quality of care standards; performance measurement, information and reporting strategies, licensing standards, credentialing/recertification processes, periodic reviews and external reviews. We are not requiring that States meet specific, unified standards regarding access to and quality of care. However, the regulation at § 457.495 does require States to assure the quality and appropriateness of care provided under the State plan. As part of the State's assurances, each State agency would be expected to assure that all covered services are available and accessible to program enrollees. This means that all covered services would be available within reasonable time frames and in a manner that ensures continuity of care, adequate primary and specialized services, and access to providers appropriate to the population being served under the SCHIP plan. We believe this assurance is sufficient to address the concerns of the commenters.

Comment: One commenter recommended that quality of care standards reflect professional judgment and local standards of care as distinguished from standards of care developed by third-party payers or fiscal intermediaries.

Response: We encourage States, as they create methods of assuring and evaluating quality of care provided to SCHIP participants, to take into consideration sources of quality of care standards and to make a determination about whether to incorporate standards endorsed or used by local providers, national provider associations, national health research institutes, or health

insurance or managed care organizations into their State plan.

Comment: Several commenters supported the requirement in § 457.735(a) that States describe methods of assuring the quality and appropriateness of care under SCHIP, particularly with regard to well-baby and well-child care, immunizations, and access to specialty care. One commenter suggested that HCFA use the phrase "access to specialty services" rather than the phrase "access to specialists" in § 457.735(b).

Response: We considered the commenters' suggestion and concluded that modifying the term "access to specialists" with the clarification of "access to specialists experienced in treating the enrolled's medical condition" would provide broader assurances that the children identified in § 457.495(c) would have access to the appropriate specialty services. Therefore, we have revised § 457.495(c) accordingly.

Comment: We received several comments applauding the inclusion of well-adolescent care with well-child care in the quality assurance requirements at § 457.495. Commenters suggested including the word "adolescent" in the definition of well-baby and well-child services and using the term in connection with well-child care throughout the regulation. The commenters indicated that they believe we should focus on the unique health needs of adolescents, which make up approximately 39 percent of SCHIP eligible youth, because their health needs differ from those of younger children. The commenters also urged HCFA to list specifically in the regulation medical sources that have guidelines for infants, children and adolescents. In these commenters' view, these sources should include the American Academy of Pediatrics' "Guidelines for Health Supervision of Infants, Children and Adolescents," the American Medical Association's "Guidelines for Adolescent Preventive Services," and the American College of Obstetricians and Gynecologists' "Primary and Preventive Health Care for Female Adolescents."

Response: We appreciate the commenters' support of our emphasis on assuring the quality and appropriateness of care for children and our specific reference to certain types of adolescent care. While understand the view that this emphasis is important at § 457.495, because of our concern for assuring quality and appropriateness of care, we have not adopted the commenters suggestion with respect to using this terminology throughout the

rest of the final rule. The definition of child for purposes of SCHIP at § 457.10 and section 2110(c)(1) of the Act indicates that a "child" is an "individual under the age of 19." Adolescents within this age range are clearly included in this definition and therefore we have not included the term in other references to well-baby and well-child care. Because we are not requiring that States adopt specific standards of care, we are not including the commenters' list of sources in the regulation text. We are including the commenters' listing here in the preamble so that States may consider these sources as recommendations in developing their own standards.

Comment: One commenter noted that accreditation is a method widely used by commercial purchasers to assure the quality of care provided by health plans. The commenter noted that accreditation, a comprehensive assessment of the quality of a health plan, is particularly useful in assessing the effectiveness and timeliness of procedures used to monitor and treat enrollees with serious medical conditions. The commenter urged HCFA to acknowledge that a State using HEDIS (Health Plan Employer Data and Information Set) measures would meet the State plan requirements set forth in this section. The commenter noted that HEDIS includes measures that specifically address the elements of care within SCHIP including:

- Childhood and adolescent immunizations;
- Use of appropriate medications for people with asthma;
- Children's access to primary care managers (PCPs);
- Annual dental visits;
- Well child visits in the first 15 months, third, fourth, fifth, and sixth years of life;
- Adolescent well visits;
- Ambulatory care;
- Inpatient utilization;
- Ratings of personal doctor, nurse, specialist;
- Rating of health care;
- Rating of health plan;
- Getting needed care and getting care quickly;
- How well doctors communicate;
- Courteous and helpful staff; and
- Customer service and claims processing.

Response: States have flexibility in determining the State-specific performance measures they will use in determining quality and access to care. In making these determinations, States have the ability to utilize those data collection tools and analysis

methodologies that are most suited to the circumstances of their SCHIP program. HEDIS is one of several tools we recommended in the proposed regulation that States consider as they design ways of measuring appropriateness and quality of care in SCHIP, but there may be other tools States may wish to consider. Specifically, in the preamble to the proposed rule, we recommended that States refer to several tools including the Consumer Assessments of Health Plans Study (CAHPS), the U.S. Preventive Services Task Force Guidelines, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, and the Office of Disease Prevention and Health Promotion's Health People 2000 and Healthy People 2010.

Comment: One commenter cautioned HCFA that while HEDIS is a widely accepted and adopted collection system, it has limitations in its usefulness for monitoring performance under SCHIP. The commenter urged HCFA to work with NCQA to understand these limitations and the explore ways to address them. Additionally, the commenter encouraged HCFA to include the American Academy of Pediatrics Guide for Health Supervision III to the list of standards, benchmarks, and guidelines states should look to for performance measures.

Response: We agree that the suggested performance measure guidelines mentioned in the preamble to the proposed rule all have certain limitations that the States should take into consideration as they develop strategies for measuring performance goals related to their strategic objectives. Additionally, we encourage States to consider the American Academy of Pediatrics Guide for Health Supervision III in developing their performance measures.

Comment: Commenters recommended that we require States to include procedures to monitor the extent to which the program has sufficient network capacity, including providers and specialists who serve the particular needs of the adolescent enrollees, both male and female, and provides services such as women's health services, family planning and transitional services. According to these commenters, the monitoring should include measures relevant to the care of adolescents, (annual well-adolescent visits, adolescent immunization rates, etc.) and immigrants, and access to services without unreasonable delay.

Response: We have not adopted the commenters' suggestions. Section 457.495 requires States to include in the

State plan a description of the methods that a State uses for assuring the quality and appropriateness of care and for ensuring access to covered services provided under an SCHIP plan. It is therefore, not appropriate to include a list of specific types of services, specialists, or groups; and risk unintentionally excluding an area that also needs attention. However, we did include language regarding access to specialists in general in order to emphasize the need for such access. We have also required States to provide a decision regarding the authorization of health services within 14 days of the service being requested. A possible extension to this 14 day period may be granted in the event that the enrollee requests an extension or the physician or the health plan determines that additional information is required. All such decisions must be made in accordance with the medical needs of the patient. The language of section 457.495 as finalized, allows us to address the concerns of the commenters while allowing States the flexibility the SCHIP statute provides them.

Comment: One commenter indicated that it was difficult to determine the applicability of the requirement to assure appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions for fee-for-service programs. The commenter believed that the quality of care monitoring requirement in § 457.495(a) is sufficient to protect enrollees and that the requirement at § 457.495(b) regarding complex and serious medical conditions should be eliminated.

Response: We disagree with the commenter. Because of the importance of ensuring that children with chronic, serious or complex medical conditions receive continuous and appropriate care, with the ability to access specialists as often as needed, particular attention is necessary in specifying the requirement at § 457.495. We understand that it is more difficult for States to implement this requirement in the fee-for-service sector than it would be in a managed care environment. However, in order to assure quality care to participants with chronic, serious or complex medical conditions, it is essential that States provide specific assurances that they have established appropriate procedures to monitor and treat these participants whether they are enrolled through fee-for-service programs or through MCEs. Therefore, we have retained the requirement at § 457.495(b), as revised.

Comment: One commenter urged HCFA to require the States to describe

procedures for providing case management to those with complex and serious medical conditions. The commenter believed that quality of care for those with complex medical conditions is greatly enhanced by case management. The commenter also urged HCFA to require States' to include appropriate peer review by pediatricians and appropriate pediatric specialists in their quality assurance mechanism.

Response: While States may want to establish procedures for providing case management to enrollees with chronic, complex or serious medical conditions to enhance quality and access to care for those participants, we have not required all States to use that particular method to assure quality and appropriateness of care. We note that case management is one service that States may, but are not required to, provide under § 457.402. However, other methods to assure quality and appropriate care are also acceptable and may be just as effective, depending upon the design of the State's SCHIP.

Comment: One commenter suggested that we revise § 457.495(b) as follows: "States must assure appropriate and timely procedures to monitor and treat enrollees with complex, serious or chronic medical conditions (including symptoms) including access to appropriate pediatric, adolescent and other specialists and specialty care centers and must assure that children with complex, serious or chronic medical conditions receive no lower quality of care than received by children with special health care needs served by the State's programs under title V of the Social Security Act."

Response: We will modify the phrase "complex and serious", to add the term "chronic", as suggested by the commenter. In addition, to provide further flexibility, we are changing the word "and" to "or"; and the phrase will be written as, "chronic, complex or serious". We believe this phrase encompasses the symptoms of these enrollees, making further specification unnecessary. We have also revised the requirement for access to specialists within that provision to read, "access to specialists experienced in treating the specific medical condition* * *" We believe the addition of these terms in § 457.495(b) assures that SCHIP programs will adequately serve the health needs of enrollees with chronic, complex or serious medical conditions, by assuring that children with these conditions will have access to care from specialists most adequately suited to meet the child's needs. Since States have the flexibility to establish their own standards for assuring appropriate

treatment and quality of care, we do not agree with the commenter's suggestion that we should specify the inclusion of specialty care centers or particular standards of care.

Comment: One commenter mentioned several times throughout its comments that access to dental services is a problem under Medicaid and that HCFA should take action to correct this problem.

Response: While Medicaid coverage of dental services is not the subject of this regulation, we would like to bring to the attention of the commenter the HCFA/HRSA Oral Health Initiative (OHI) which is an ongoing effort to improve access to high quality oral health services for vulnerable populations, particularly children enrolled in Medicaid and SCHIP. HCFA teamed with HRSA almost two years ago and initiated the OHI in a effort to bring together Federal staff, State Medicaid agencies and national, State and local level dental organizations to recognize and address this issue. Both HCFA and HRSA recognize that resolving barriers to oral health access in Medicaid and SCHIP must begin with the understanding that Medicaid and SCHIP are programs that rely upon Federal-State partnerships: the Federal government provides broad guidelines under which States implement individual programs. Both HCFA and HRSA believe that solutions to oral health disparity in Medicaid and SCHIP will most likely be found at the local and State levels. Both agencies seek to provide resources, guidance and technical assistance necessary to enable States and localities to better address their local oral health concerns.

Some activities that have been undertaken by the OHI include: co-sponsoring a national leadership conference that brought together for the first time the State Medicaid and State Dental Directors with the leadership of the dental profession; collaborating with the private sector (that is, the American Dental Association convened a second national leadership conference for stakeholders to continue the progress and dialogue achieved in the first meeting and also to include State legislators in the process); supporting State dental summits/workshops to provide the opportunity for State level players to meet with each other on a face-to-face basis to address oral health problems specific to their States and develop State-specific strategies and implementation plans; promoting best practices by providing State dental officials the opportunity to share common dental concerns and potential best practices by initiating and

supporting a privately managed electronic list serve which connects, for the first time, Medicaid program officials in each State with each other, and with State health officials and the Federal OHI team. Discussion of further activities undertaken by HCFA and the OHI to improve the oral health of this vulnerable population is contained in the Department responses to the April 27, 1999 report of the General Accounting Office (GAO), "Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations." This report is available from the GAO web site at www.gao.gov.

Finally, in an effort to focus attention on the oral health issues and to build an oral health infrastructure, HCFA has appointed a full-time Chief Dental Officer to serve as a focal point for oral health issues and has identified staff in each HCFA Regional Office to serve as Medicaid dental coordinators.

Comment: Several commenters suggested that the regulation include language to specifically require access to various types of providers, such as, pediatric and adolescent specialists, and obstetricians/gynecologists. In addition, one commenter suggested that State plans should be required to assure that female adolescents have direct access to women's health specialists and that pregnant adolescents be permitted to continue seeing their treating provider through pregnancy and the post-partum period in instances where the contracting plan or provider has left the SCHIP program.

Response: We have not adopted the commenters' suggestions. Section 457.495 requires that the State plan include assurances of the quality and appropriateness of care and services provided under a State plan including treatment of chronic, serious or complex medical conditions and access to specialists. This requirement addresses the concerns of the commenters while allowing States the flexibility to establish the means by which they will assure access to appropriate care that the SCHIP program provides them. This regulation requires States to ensure access to providers appropriate to the population being served under the State plan.

Comment: Two commenters recommended that we revise the regulation to provide that a State and its participating contractors must provide services as expeditiously as the enrollee's health condition requires. The commenter also suggested time frames of approval of a request for services within seven calendar days after receipt of the request for services, with a possible extension of fourteen days. The

commenters also recommended an expedited time frame if the physician indicates, or the State/contractor determines that following ordinary time frames could seriously jeopardize the enrollee's life or health or ability to regain maximum function, to be no later than 72 hours after receipt of the request for services, with a possible extension of up to 14 additional calendar days. Another commenter suggested requiring a response within seven days to an initial request for service or within 72 hours for an expedited procedure.

Response: We recognize the commenters' concerns and have addressed these issues in new subpart K, Applicant and Enrollee Protections, at § 457.1160.

E. Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

1. Basis, Scope, and Applicability (§ 457.500)

A State that implements a separate child health program may impose cost-sharing charges on enrollees. A State that chooses to impose cost-sharing charges on enrollees must meet the requirements described in section 2103(e) of the Act. In proposed § 457.500, we set forth section 2103(e) of the Act as the statutory basis for this subpart, containing cost-sharing provisions. As proposed, this subpart consists of provisions relating to the imposition under a separate child health program of cost-sharing charges including enrollment fees, premiums, deductibles, coinsurance, copayments, and similar cost-sharing charges. We proposed that these provisions apply to all separate child health programs regardless of the type of coverage (benchmark, benchmark equivalent, Secretary-approved or existing comprehensive State-based coverage) provided through the program.

We noted in the preamble that these requirements apply when a State with a separate child health program purchases family coverage for the targeted low-income child under the waiver authority of section 2105(c)(3) of the Act and proposed § 457.1010 and when a State provides premium assistance for coverage under a group health plan as defined in § 457.10. We proposed that this subpart does not apply to Medicaid expansion programs. In this final rule, we revised the statutory basis at § 457.500(a) to include section 2101(a) of the Act, which describes that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income

children in an effective and efficient manner.

Comment: A number of commenters noted that the numerous protections written into the Medicaid statute were not written into the SCHIP statute because Congress clearly recognized that these populations are different and intended that they be treated differently. The commenters noted that cost-sharing gives working families a sense of pride in sharing the cost of medical services, just like their friends, neighbors, and relatives who have employer-based insurance. They also indicated that asking families to track their own cost-sharing expenditures contributes to the development of self-sufficiency. Some commenters noted that establishing low levels of cost-sharing will encourage substitution of coverage.

Response: We have implemented §§ 457.500 through 457.570 of the final regulation under the authority of section 2103(e) of the Act. Congress included cost-sharing protections for children covered under SCHIP through separate child health programs, in recognition of the important role that affordability plays in determining whether a child has access to health care insurance and essential health care services for their families. High cost-sharing charges could result in low-income families choosing to remain uninsured, dropping insurance coverage, or avoiding utilization of necessary health care services. Increased cost sharing may also encourage enrollees to access health care only during times when care is most expensive (that is, during emergency or critical health care situations). We have retained States' ability to rely on a methodology for tracking cost sharing that places some of the responsibility on the enrollee. As noted in the preamble to the proposed rule, we do, however, encourage the use of more formal tracking mechanisms that ease any tracking or administrative burden on enrollees and providers, such as a swipe card. While we recognize that low levels of cost sharing may encourage substitution, States must meet the requirements in subpart H, Substitution of Coverage, that are intended to limit the occurrence of substitution.

Comment: One commenter suggested that HCFA revise this section to apply the SCHIP copayment rules to Medicaid expansion programs, not just separate child health plans. The commenter believed that this revision would effectuate Congressional intent, which was to allow States flexibility in implementing SCHIP plans.

Response: Section 2103(e)(4) of the Act provides that the cost-sharing

requirements and limitations established pursuant to section 2103(e) do not affect the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in a Medicaid expansion program under section 2101(a)(2). Therefore, Congress has made it clear that these cost-sharing provisions were intended to apply to separate child health assistance programs only. The title XIX cost-sharing rules apply to Medicaid expansion programs, and these rules generally prohibit cost sharing for children. Therefore, the reference to Medicaid expansion programs in § 457.500(c) has been removed.

Comment: One commenter recommended that we include language in the preamble advising States that they must ensure that cost-sharing requirements are administratively workable and not unduly burdensome for managed care entities.

Response: We agree with the commenter. States should strive to impose cost-sharing charges in a manner that eases administrative burden on managed care entities and their participating providers and thereby promotes provider participation in SCHIP. We believe the cost-sharing provisions in §§ 457.500 through 457.570 of this final rule provide States with flexibility to use a variety of strategies to implement these requirements while at the same time providing enrollees with important protections.

2. General State Plan Requirements (§ 457.505)

Section 2103(e)(1)(A) of the Act specifies that a State plan must include a description of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Section 2103(e)(1)(A) also specifies that any such charges be imposed pursuant to a public schedule. In accordance with the statute, at § 457.505, we proposed that the State plan must include a description of the amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed. We further proposed that the State plan include a description of the methods, including the public schedule, the State uses to inform enrollees, applicants, providers, and the general public of the cost-sharing charges, the cumulative cost-sharing maximum, and any changes to these amounts.

We also proposed that States that purchase family coverage or offer premium assistance programs must describe how they ensure that enrollees are not charged for copayments,

coinsurance, deductibles, or similar fees for well-baby and well-child care services and that they do not charge American Indian/Alaska Native (AI/AN) children cost sharing. We also proposed that a procedure that primarily relies on a refund given by the State to implement the requirements of this subpart is not an acceptable procedure. We proposed that in States that purchase family coverage or establish premium assistance programs, the State also must describe in its State plan the procedures used to ensure that enrollees are not charged cost sharing over the cumulative cost-sharing maximums proposed in § 457.560. We emphasized that this process must not primarily rely on a refund for cost sharing paid in excess of the cumulative cost-sharing maximum. In § 457.505, we have added a paragraph (c) that will require States to include in the State plan a description of the disenrollment protections required under § 457.570. We have also added paragraph (e) in this section to reduce redundancy and more clearly identify the State plan requirements when a State uses a premium assistance program.

Comment: Several commenters did not agree with the statement in the preamble that suggested that providers could bill the State directly, so that enrollees are not inappropriately charged for certain services. They noted that many health plans are not willing to make the administrative changes necessary to bill the State agency instead of the enrollee and, in light of the difficulties, proposed that a refund component be a valid option.

Response: We disagree. States should establish adequate procedures to ensure the requirements for cost-sharing charges are met and to educate both the provider and the enrollee regarding cost-sharing obligations. Having providers bill the State directly is one option States may use as part of these procedures. We also note that we have not prohibited the use of refunds in all circumstances, but we do require that a State not use a refund as the primary method for assuring compliance with cost-sharing prohibitions and cumulative cost-sharing maximums. Other examples of tracking procedures include informing enrollees that they are approaching the cumulative cost-sharing maximum right before the cap is reached, or sending monthly letters to providers to inform them of which enrollees do not need to pay copayment amounts as of a certain date. We have revised proposed section § 457.505(d) to clarify that when States provide premium assistance for group health plans, cost-sharing charges are not

permitted for well-baby and well-child care services; cost sharing is not permitted for AI/AN children; and enrollees must not be charged cost sharing that exceeds the cumulative cost-sharing maximum. These provisions must be described in the State plan. Finally, the provision specifying that “a procedure that primarily relies on a refund given by the State for overpayment by an enrollee is not an acceptable procedure for purposes of this subpart” has been moved to § 457.505(e) for clarity.

Comment: One commenter suggested that we define the word “primarily” as used in § 457.560 for a variety of situations. For example, they indicated that a State may not be able to ascertain at the time of eligibility determination whether an applicant is an AI/AN due to the lack of verification of AI/AN status on the part of the applicant and/or the lack of cooperation in verification on the part of the tribe. In this situation, the State may not waive cost-sharing charges for the individual and, in their view, the only way a State could comply with the requirement that the AI/AN population be excluded from cost sharing would be to use a procedure of refunds for overpayments, once AI/AN status was verified.

Response: We realize that there may be unforeseen circumstances when an enrollee has paid cost sharing that either should not have ever been charged or is in excess of the cost-sharing limits. In these cases, refunds will be necessary. However, refunds should not be the State's only or ongoing method to ensure that cost sharing does not exceed the regulatory limits. The State should inform each enrollee of the precise amount of the cumulative cost-sharing maximum based on the enrollee's individual family income at the time of enrollment and/or reenrollment or, in the case of a set out-of-pocket cap, inform the enrollee of cost sharing as required under § 457.525. Rather than rely on a refund mechanism, the State should educate the enrollee regarding the cumulative cost-sharing maximum and when not to pay cost sharing for the applicable time period. In the case of the AI/AN population, States should provide accessible information to the population about the State requirements for demonstrating AI/AN status and, as in other instances, seek to minimize the use of refunds as a method for compliance with the cost-sharing requirements of Subpart E.

3. Premiums, Enrollment Fees, or Similar Fees: State Plan Requirements (§ 457.510)

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed pursuant to a public schedule. At § 457.510 we proposed that when a State imposes premiums, enrollment fees, or similar fees on SCHIP enrollees, the State plan must describe the amount of the premium, enrollment fee, or similar fee, the time period for which the charge is imposed, and the group or groups that are subject to these cost-sharing charges. We also proposed that the State plan include a description of the consequences for an enrollee who does not pay a required charge. We noted in the preamble that the State should indicate enrollee groups that are exempt from any disenrollment policy.

In addition, proposed § 457.510 set forth the requirement that the State plan include a description of the methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in proposed § 457.560, pursuant to section 2103(e)(3)(B) of the Act. We noted in the preamble to the proposed rule that the State's methodology should include a refund for an enrollee who accidentally pays more than his or her cumulative cost-sharing maximum. We proposed that a methodology that primarily relies on a refund by the State for cost-sharing payments made over the cumulative cost-sharing maximum will not be an acceptable methodology.

We discussed the findings of the George Washington University study on the types of methods States and private insurance companies use to track cost-sharing amounts against an enrollee's out-of-pocket expenditure cap. We described several examples of methods States could use to ensure that enrollees do not exceed the cumulative cost-sharing maximum. We solicited comments on tracking mechanisms States can use that do not place the burden of tracking cost-sharing charges on the enrollee.

Comment: Two commenters specifically urged HCFA to encourage States to adopt cost-sharing provisions for premiums, enrollment fees, and similar fees, as opposed to cost-sharing charges related to the provision of services (copayments, coinsurance, deductibles, or similar cost-sharing charges). The commenter asserted that applying cost sharing to premiums

instead of services would avoid the tracking burden altogether.

Response: We agree that it would be easier to track cost sharing if the State only imposed premiums or enrollment fees and that this would relieve States from the burden of tracking cost sharing associated with services. However, the statute provides States with flexibility to design cost sharing that meets their policy goals. While some States may wish to design cost sharing in a way that avoids or minimizes the need for tracking, others may favor the use of copayments to discourage over-utilization. We therefore encourage States to consider the ease of tracking along with many other factors in devising their cost-sharing systems, but do not prescribe or recommend a specific cost-sharing design.

Comment: One commenter recommended that HCFA revise paragraph (d) of this section to require that State plans include a description of the disenrollment protections established pursuant to § 457.570, in addition to the consequences for an enrollee who does not pay a charge. The commenter noted that § 457.570 requires disenrollment protections; however, nothing in the regulation currently requires States to describe these processes in the State SCHIP plan.

Response: We agree with this comment. We intended to require States to include disenrollment protections in their State plans, as stated in the preamble to the proposed regulation. Therefore, we have revised § 457.510(d) and § 457.515(d) to include the State plan requirement that States provide a description of their disenrollment protections as required under § 457.570.

Comment: Several commenters indicated that HCFA should require, rather than recommend, that States develop tracking mechanisms that do not rely on the beneficiary demonstrating to the State that he or she has met the cumulative cost-sharing maximum. The commenters did not believe that the finding of the George Washington study (that States were not charging high enough cost-sharing to make it likely that families reached their cap) was good cause for a weaker standard. The commenters noted that States are currently experiencing very good budget climates that are likely to weaken at some point, perhaps causing States to raise their cost-sharing requirements. They also observed that expansion to higher income eligibility groups may cause States to increase cost sharing under SCHIP. Moreover, the commenters believed that all States could develop the capability to track enrollees' cumulative cost sharing if

required, since some States do so currently. And the commenters urged that the requirement be imposed on States and contracting plans rather than individual providers, since such a responsibility could deter provider participation in SCHIP.

Response: As part of the study conducted by George Washington University, States were invited to a meeting to discuss tracking of cost sharing under SCHIP. During this discussion, HCFA noted that some States were capable of using sophisticated tracking mechanisms like swipe cards to track their cost sharing. These States typically have a large concentration of managed care entities with participating providers who already have in place hardware that aids in tracking cost sharing for the SCHIP population. However, States with providers located in rural areas, and with providers who are not part of managed care networks, have indicated that it is administratively expensive to require States to put in place a sophisticated swipe card mechanism that would track cost sharing. Therefore, we have decided to continue to encourage States to use a tracking mechanism that does not rely on the enrollee, but will not require such a tracking mechanism due to implementation challenges and resource limitations in different States.

States must distribute, as part of the information furnished consistent with §§ 457.110 and 457.525 and general outreach activities, materials that inform the enrollee regarding his or her cost-sharing obligations, and assist the family in keeping track of the charges paid. At a minimum, States are required to include the schedule of cost-sharing charges, and the dollar amount of the enrollee's family's cumulative cost-sharing maximum. We also recommend that States educate the enrollee's family regarding tracking cost sharing against the cumulative cost-sharing cap.

Comment: Several commenters disagreed with our provision at § 457.510(e) that "a methodology that primarily relies on a refund given by the State for overpayment (of cost sharing) by an enrollee is not an acceptable methodology." These commenters indicated that the use of a refund process can be the most cost effective and simple approach to ensuring that cost sharing does not exceed limits, or that individuals exempt from cost sharing are not required to pay when it is not appropriate. The commenters believe States should be given the flexibility to develop their own process as long as the process guarantees that families will not have to pay cost-

sharing charges for which they are not responsible. The commenters suggested that we consider that States are limited to a 10 percent cap on administrative costs, and that overly prescriptive measures added to administrative costs can take away from other important administrative functions, such as outreach and eligibility determinations. Several commenters also questioned how these provisions apply to a State that administers SCHIP through employer-sponsored health insurance plans.

Response: As stated in an earlier response, we recognize that there are situations in which the use of a refund methodology may be necessary. However, we believe States generally must be proactive and provide specific procedures for enrollees and their families to follow so that they are not overcharged cost sharing. A State methodology that merely reimburses or refunds enrollees for any cost sharing in excess of the cumulative cost-sharing maximum without including steps to help enrollees avoid overpayment will require the enrollees to outlay cash to obtain access to services that they should have been able to access without the burden of cost sharing. We view such a refund policy to be contrary to the limits on cost sharing set forth in section 2103(e) of the Act.

Comment: One commenter suggested that we revise this section to require that, in describing the methodology used to ensure that total cost-sharing liability for an enrollee's family does not exceed the cumulative cost-sharing maximum, the State plan must describe how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost-sharing maximum. The commenter noted that the preamble stated that the description of the methodology must explain these areas. The commenter asked that this language be incorporated into the regulation.

Response: We agree with the general point that the commenter was making, that States should be required to disclose the principles used to calculate cumulative cost sharing maximums, but we believe such disclosure is equally important on an individual level as on a statewide level. Thus, we are adding paragraph (d) to 457.560, to require that the States provide the enrollee's family the precise dollar amount of the cumulative cost-sharing maximum at the time of enrollment and at the time of re-enrollment. However, we have not revised § 457.510 because it already requires the State plan to describe the methodology for ensuring that cost sharing for a family does not exceed

cumulative maximums, and this must include the information described above. If the description submitted in a proposed State plan or amendment does not include a full explanation of how income is calculated for purposes of the cumulative cost sharing maximum and other relevant details, HCFA requests this information in reviewing the submission.

Comment: One commenter stated that, if a family must pay more than the customary rate for child care due to the special needs of the child, there should be a mechanism for that additional cost to be considered when determining financial status. Children with chronic conditions should be defined to include children with mental health and substance abuse conditions. Another commenter agreed with the finding of the George Washington study that children with chronic conditions or special needs often have expenses for related, non-covered services, which can create a tremendous financial burden for the family. The commenter recommended that the statute be changed to eliminate the cost-sharing provision for eligible children with chronic illness or other special needs. In this commenter's view, at a minimum, all related expenses should be counted toward the cumulative cost-sharing cap for these children. The commenter also agreed with the George Washington study's recommendation that States assign a case manager to children with chronic needs to assure that cost sharing does not exceed the cumulative cost-sharing maximum for these children.

Response: Title XXI does not include any special provision regarding cost sharing for children with special needs or chronic conditions and we appreciate the commenter's recognition that this issue is driven by the statute. States may consider the additional costs, including the costs associated with child care and case management, borne by families of children with special needs or chronic conditions when imposing cost sharing on this population, but HCFA does not have statutory authority to require that States take these costs into account. In addition, States may, at their option, exempt families of children with special needs or chronic conditions group from cost sharing, because the added costs of care can significantly reduce their disposable income. However, we have not specifically required States to exempt these children, and have therefore not included the commenter's recommendation in the regulation text.

Comment: Several commenters opposed our suggestion in the preamble that States count non-covered services

towards the cumulative cost-sharing maximum.

Response: We do not require States to count the costs of non-covered services towards the cumulative cost-sharing maximum. However, we encourage States to consider the additional costs of uncovered services particularly for families with special needs children, when imposing cost sharing. States may pursue this policy option by counting non-covered services toward the cumulative cost-sharing maximum or by implementing other State policies to limit the burden on such families.

4. Co-Payments, Coinsurance, Deductibles, or Similar Cost-Sharing Charges: State Plan Requirements (§ 457.515)

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed. We proposed that the State plan describe the following elements regarding copayments, coinsurance, deductibles or similar charges: the service for which the charge may be imposed; the amount of the charge; the group or groups of enrollees to whom the charge applies; and the consequences for an enrollee who does not pay a charge. We proposed that the State plan describe the methodology used to ensure that total cost-sharing liability for an enrollee's family does not exceed the cumulative cost-sharing maximums. This description must explain how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost-sharing maximums.

Finally, we proposed, in accordance with the prudent layperson standard in the Consumer Bill of Rights and Responsibilities, that States must provide assurances that enrollees will not be held liable for costs for emergency services above and beyond the copayment amount that is specified in the State plan. Specifically, we proposed that the State plan must include an assurance that enrollees will not be held liable for additional costs, beyond the copayment amounts specified in the State plan, that are associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network. In addition, we require that the State will not charge different copayment amounts for emergency services, based upon the location (in network or out of network) of the facility at which those services were provided. We indicated that we welcomed public comments on our proposed policy. In this final rule, we

have added a provision to § 457.515(d) that States must describe in the State plan the disenrollment protections adopted by the State pursuant to § 457.570.

Comment: One commenter suggested that §§ 457.510(d) and 457.515(d), which require that the State plan describe the consequences for an enrollee who does not pay a charge, be revised to also require State plans to describe the consequences for a provider who does not receive a payment from an enrollee. The commenter indicated that providers should have information on the State's policy regarding unpaid copayments. The commenter questioned if providers may deny services to, or pursue collection from, enrollees who refuse to pay cost sharing. The commenter also asked if States will increase payments to providers when enrollees do not pay.

Response: Unlike under the Medicaid program, we do not have the statutory authority to prevent providers under separate child health programs from denying services to enrollees who do not pay their cost-sharing charges. Nor do we have clear authority to preclude providers or the State from billing the enrollee for unpaid cost-sharing charges. State plans should, consistent with fairness and equity, ensure that the provider or State gives the enrollee a reasonable opportunity to pay cost sharing before pursuing collection. Providers should refer the enrollee back to the State if he or she is demonstrating a pattern of non-payment, so that the State can review the financial situation of the enrollee. For example, the State should inquire whether the enrollee's income has dropped to a Medicaid eligibility level, or to a level of SCHIP qualification that does not require cost sharing or requires it at a lower level. We also suggest that States maintain open communication with providers regarding any financial losses for the provider resulting from non-payment of cost sharing. However, we note that the State's policy in this area is a matter of State discretion under this regulation.

Comment: One commenter urged HCFA to add a provision making clear that an enrollee may not be denied emergency services based on the inability to make a copayment, regardless of whether the provider is inside or outside of the enrollee's managed care network. The commenter also recommended that we include in the preamble a discussion of the obligations of emergency services providers under the Emergency Medical Treatment and Active Labor Act (EMTALA).

Another commenter suggested that as a general rule for all SCHIP services, including emergency services, cost-sharing limits should apply only to services delivered through network participating providers. If there is to be an exception to this rule for emergency services, then cost-sharing limits should only apply to out-of-network emergency service providers that are not within a reasonable distance of network participating providers.

Response: While this is not an appropriate vehicle to discuss EMTALA responsibilities at length, when those responsibilities are triggered, a hospital cannot turn away a patient solely because of inability to pay. In addition, § 457.410 requires States to provide coverage of emergency services; § 457.495 requires States to ensure that SCHIP enrollees have access to covered services, including emergency services; and § 457.515 specifies that enrollees cannot be held liable for cost sharing for emergency services provided outside of the managed care network.

If an enrollee goes outside of a managed care network to receive non-emergency services that are not authorized by the health plan, then the enrollee may be responsible for the full cost of the services provided. However, because of the nature of emergency services and the importance of ensuring that enrollees receive such services without delay or impediment, such a situation is not reasonable. Thus, as we discuss further below, we have retained the regulation text at § 457.515(f) providing that enrollee financial responsibility for emergency services must be equal whether the enrollee obtains the services from a network provider or out-of-network.

Comment: Several commenters supported the proposed requirement that beneficiary cost sharing for emergency services can not vary based on whether the provider is participating in a managed care network or not. One commenter specifically asserted that the use of differential copayments would be contrary to the spirit of the "prudent layperson" standard for emergency services. Another commenter recommended retaining or lowering the proposed maximum limit for copayments on emergency services, rather than raising the limit to levels parallel to those permitted in the Medicare+Choice programs, in light of the inability of many low-income families to access this amount at the time of an emergency.

Response: In keeping with the prudent layperson standard of assuring immediate access to emergency services, we have retained the prohibition against

differential copays based upon location (in-network or out-of-network) under § 457.515(f). These services are required to address an emergency and can be time sensitive, and higher copayment levels for out of network providers might result in an unacceptable delay to determine whether the provider participates in the enrollee's managed care network. Furthermore, differential copayment levels might affect the ability of enrollees to access the closest and most accessible provider.

We have neither raised nor lowered the proposed permissible copayment levels for emergency services, because we believe the overall cost-sharing limitations are sufficient to protect enrollee families. We have not adopted the Medicare+Choice policy that would have permitted a \$5.00 copayment for emergency medical services. The cost sharing provisions at § 457.555 will apply to emergency medical services.

Comment: We received a comment on our statement in the preamble that we considered adopting the Medicare+Choice policy regarding emergency services obtained outside of the provider network. The commenter noted that limitations on emergency room cost sharing at Medicare+Choice levels, whether in network or out of network, could be administratively burdensome to group health plans and participating providers, and might dissuade such entities and practitioners from contracting with SCHIP.

Response: As noted above, we have not adopted the Medicare+Choice policy described in the preamble to the proposed rule. We do note, however, that premium assistance programs are subject to the same cost-sharing requirements and protections as other types of SCHIP programs. Such protections are required by statute and recognize the unique financial constraints of the SCHIP population. In situations where employer plans charge more than is permissible under these rules, the State will need to develop a mechanism to prevent enrollees from paying excess charges.

5. Cost Sharing for Well-Baby and Well-Child Care (§ 457.520)

Under section 2103(e)(2) of the Act, the State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby and well-child care services in either the managed care or the fee-for-service delivery setting. At proposed § 457.520, we set forth services that constitute well-baby and well-child care for purposes of this cost-sharing prohibition. We proposed to define these well-baby and well-child services

consistent with the definition of well-baby and well-child care used by the *American Academy of Pediatrics* (AAP) and incorporated in the Federal Employees Health Benefits Program (FEHBP) Blue Cross and Blue Shield benchmark plan.

We also proposed to apply the prohibition on cost sharing to services that fit the definition of routine preventive dental services used by the *American Academy of Pediatric Dentistry* (AAPD) when a State opts to cover these services under its program.

We proposed at § 457.520 that the following services are considered well-baby and well-child care services for the purposes of the prohibition of cost sharing under section 2103(e)(2):

- All healthy newborn inpatient physician visits, including routine screening (whether provided on an inpatient or on an outpatient basis).
- Routine physical examinations.
- Laboratory tests relating to their visits.
- Immunizations, and related office visits as recommended in the AAP's "Guidelines for Health Supervision III" (June 1997), and described in "*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*" (Green M., (ed.). 1994).
- When covered under the State plan (at the State's option) routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the AAPD's current Reference Manual (Pediatric Dentistry, Special Issue, 1997–1998, vol 19:7, page 71–2).

Comment: One commenter noted that the language of this section is ambiguous in stating that the "State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby/well child care services as defined by the State." HCFA should clarify that no preventive service as defined by the Guidelines for Health Supervision III (including the appended Recommendations for Preventive Pediatric Health Care) and Bright Futures is subject to cost sharing, as was intended by the underlying statute.

Response: We agree with the commenter and have revised § 457.520(a) to be clearer that a State may not impose cost sharing on services that would ordinarily be considered well-baby and well-child care. As described in subpart D, Benefits, States may define well-baby and well-child services for coverage purposes. While this may provide States flexibility in determining the appropriate scope of

benefits, such flexibility is not appropriate with respect to cost sharing which might deter appropriate utilization of covered services. Thus, we are specifying in § 457.520(a) that cost sharing may not be imposed on any covered services that are also within the scope of AAP well-baby and well-child care recommendations.

Comment: One commenter noted that there are differences between the discussion of this provision in the preamble (64 FR 60913) and in the regulations text (64 FR 60955). The commenter believed the provision as set forth in the regulations text is more clear.

Response: In this final rule, we are adopting the provisions regarding well-baby and well-child care as set forth in the regulations text at § 457.520, except that we have amended these provisions to clarify the scope of services to which the prohibition on cost sharing applies.

Comment: A number of commenters expressed concern that adolescent health care services are not specifically listed as well-baby and well-child care services exempt from cost sharing. Although the preamble notes that well-child care includes health care for adolescents, the commenters urged HCFA to make specific mention of this fact in the regulation. One commenter recommended that HCFA define adolescent health care services using the schedules from the American Medical Association's "Guidelines for Adolescent Preventive Services," and the American College of Obstetricians and Gynecologists, "Primary and Preventive Health Care for Female Adolescents" as well as those of the American Academy of Pediatrics. Another commenter noted that there is no reason why a physical exam for a toddler should be exempt from cost-sharing requirements while an exam and related services for an adolescent are not.

Response: It is not necessary to add the term adolescent to the regulation because the term "child" as defined by the statute and regulation refers to enrollees under the age of 19 the cost-sharing rules set forth in this regulation apply to all children under age 19. Therefore, States cannot impose cost sharing on any well-child care services provided to an adolescent under the age of 19. In addition, the standard recommended by the AAP for routine physical exams specifically includes treatment of adolescents.

Comment: One commenter disagreed with the use of a specific immunization schedule because it may be difficult for States using employer-sponsored insurance to implement this

requirement. The commenter recommended that we revise the regulation to state "Immunizations and related office visits *as medically necessary*."

Response: We are not accepting the commenter's suggestion because immunizations recommended by the Advisory Commission on Immunization Practices (ACIP) are generally accepted as being medically necessary. The State is responsible for assuring that an enrollee does not pay cost sharing for any immunizations recommended by ACIP.

Comment: One commenter recommended that the immunization schedule include updates.

Response: As proposed, § 457.520(b)(4) prohibits cost sharing for immunizations and related office visits as recommended by ACIP. We are retaining this language in the final regulation at § 457.520(b)(4) which also indicates that updates to these guidelines must be reflected in States cost-sharing policies.

Comment: One commenter urged that HCFA remove the term "routine physical examinations" from the list of well-baby and well-child care services. The inclusion of this term is confusing in this commenter's view because almost every office visit for children entails a "physical examination" as part of the evaluation and management component of the office visit. As an alternative, the commenter recommended using the language for well-baby and well-child care services as listed in § 457.10. Other commenters recommended that routine exams be specifically tied to professionally established periodicity schedules.

Response: We agree that our intent may have been unclear. We have revised § 457.520(b)(2) to provide that the well-baby and well-child routine physical exams, as recommended by the AAP's "Guidelines for Health Supervision III", and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents", (which would include updates to either set of guidelines) may not be subject to cost sharing.

Comment: Several commenters stated that lab tests should not be exempt from cost sharing, especially given that lab tests are expensive and not always preventive. Since lab services are provided by a separate entity, outside of the office of the physician providing the well-baby and well-child care service, States should be given flexibility in determining whether to exempt lab services from cost sharing, particularly in managed care settings. One commenter requested that HCFA clarify

the intention of the provisions excluding lab services from cost sharing. The commenter questioned if the exemption is limited to laboratory tests that are associated with the well-baby and well-child visit.

Response: We have revised the regulation text at § 457.520(b)(3) to indicate that States are required to exempt from cost sharing only those lab tests associated with the well-baby/well-child routine physical exams described in § 457.520(b)(2). We believe the exemption from cost sharing for these lab tests is consistent with the statutory intent that there is no cost sharing imposed on enrollees for well-baby and well-child care services. All other lab tests that are not routine and not part of a well-baby or well-child visit may be subject to cost-sharing charges consistent with the other cost-sharing provisions of this subpart.

Comment: Several commenters indicated their view that States should have the flexibility to determine how best to improve access to dental services. In their view, the prohibition of cost-sharing for dental services may discourage States from offering dental services under SCHIP because it is an optional benefit. One commenter recommended prohibiting States from imposing copayments, deductibles, coinsurance or other cost sharing for all covered dental services. This commenter indicated that the Medicaid program has clearly demonstrated that imposing costly, difficult, and risk shifting management procedures on providers severely limits participation in such programs and therefore severely restricts access to essential oral health care for this high risk, high need population. The commenter stated that, for example, if a child arrives in a dental office without the appropriate cost-sharing funds, the practitioner must either defer the needed service, enter into costly billing procedures, or waive the money due and such waivers previously have, on some occasions, been interpreted as insurance fraud. The commenter indicated that our policy may discourage practitioners from participating in the SCHIP program and result in problems of access to care for the children with the greatest need.

Response: The majority of separate child health programs offer dental benefits and do not impose cost sharing on preventive dental services. If States were to impose cost sharing on preventive benefits, due to their limited incomes, enrollees would only access services when needed and when services are most expensive. Almost all States have elected to provide at least some dental coverage in their State

plans without cost sharing for preventive services. The cost-sharing exemption policy has not caused States to discontinue coverage of dental services thus far. In addition, we note that the cost-sharing exemption on well-baby and well-child care services is based upon section 2103(e)(2) of the Act, which provides that the State plan may not impose cost sharing on benefits for these preventive services. We have interpreted this statutory provision to support the cost-sharing exemption for routine preventive and diagnostic dental services.

6. Public Schedule (§ 457.525)

Section 2103(e)(1)(A) of the Act requires that the State provide a public schedule of all cost-sharing charges. We proposed that the public schedule contain at least the current SCHIP cost-sharing charges, the beneficiary groups upon whom cost sharing will be imposed (for example, cost sharing imposed only on children in families with income above 150 percent of the FPL), the cumulative cost-sharing maximums, and the consequences for an enrollee who fails to pay a cost-sharing charge. We also proposed that the State must make the public schedule available to enrollees at the time of enrollment and when the State revises the cost-sharing charges and/or cumulative cost-sharing maximum, applicants at the time of application, SCHIP participating providers and the general public. To ensure that providers impose appropriate cost-sharing charges at the time services are rendered, we proposed that the public schedule must be made available to all SCHIP participating providers. In this final rule, we have added § 457.525(a)(4) which indicates that the State must include in the public schedule, the mechanisms for making payments for required charges. We also added to § 457.525(a)(5) that the public schedule describe the disenrollment protections pursuant to § 457.570.

Comment: Several commenters recommended that States have the option to provide information in the public schedule that defines cumulative cost sharing as a percentage of income. The commenters requested that we clarify that States can defer responsibility for distributing the public schedule to all SCHIP providers to the managed care entities as part of their contractual obligations.

Response: States may define the cumulative cost-sharing maximum as a percentage of income in the public schedule and request that managed care entities distribute the public schedule to all SCHIP providers (although the State

retains the responsibility that the entities involved make the schedule available to providers). However, we have modified the regulation at § 457.110(b)(2) to indicate that States must calculate the precise amount of the cumulative cost-sharing maximum (the dollar amount instead of a percentage of income) that applies to the individual enrollee's family at the time of enrollment (as well as at the time of re-enrollment) to maximize the usefulness of information provided to the family and to ensure uniform calculation of the amount, maximize the usefulness of the information, and make tracking easier.

Comment: One commenter urged HCFA to include language in the preamble that "applicants" and "enrollees" include adolescents (independent from other children in their family) and that information should be directed to them about any schedule of costs. The commenters noted that adolescents often seek care on their own, not only for services that they need on a confidential basis, but for other services as well. Unless they are aware of the charges they may encounter, and the services that do not require a copayment, they may be deterred from seeking care, in this commenter's view.

Response: Section 457.525(b) specifically requires States to provide a public schedule, which includes a description of the plan's current cost-sharing charges, to SCHIP enrollees at the time of application, enrollment, and when cost-sharing charges are revised. We have added a provision at § 457.525(b)(1) requiring that States provide SCHIP enrollees the public schedule at reenrollment after a redetermination of eligibility as well. This section also requires that cost-sharing charges be disclosed to SCHIP applicants at the time of application. SCHIP enrollees, by definition, are children under age 19. In most cases, this information will be given to family members due to the age of the child. However, we encourage States to provide information about cost sharing directly to adolescent applicants and enrollees when appropriate. We also encourage States to consider the range of applicants, enrollees and family members who might benefit from the provision of this information, including adolescents, and we encourage States to describe the plan's current cost-sharing charges in language that is easily understood and tailored to the needs of target populations, consistent with section 457.110.

Comment: One commenter suggested that the requirement to provide the public schedule to applicants may be

overwhelming to both the program and the applicants. Enrollees are most interested in the information relating to the family's individual obligations.

Response: Section 2103(e)(1)(A) of the Act provides sufficient authority to require States to make a public schedule available, and to provide all interested parties with notice of cost-sharing obligation for the program. In addition, applicants should be given a chance to review the cost sharing structure prior to enrollment, so that the applicant will understand the potential costs of SCHIP and can make a reasoned choice as a health care consumer. This policy also aids in future tracking of the family's cost-sharing obligation.

Comment: One commenter recommended that HCFA require that the public schedule contain information about an enrollee's rights with respect to cost sharing, including the right to receive notice and make past due payments, as well as other protections established by the State in compliance with § 457.570.

Response: Section 457.525(a)(5) of this final rule requires that the public schedule include a description of the consequences for an enrollee who does not pay a cost-sharing charge. We are also revising this section to require States to discuss, as part of this description, the disenrollment protections it has established pursuant to § 457.570. Section 457.570 requires States to provide enrollees with an opportunity to pay past due cost sharing, as well as an opportunity to request a reassessment of their income, prior to disenrollment.

Comment: One commenter recommended that we require States to include detailed information about the cost-sharing schedule at each annual renewal and in the SCHIP application packet/pamphlet. Applications should also include information to notify participants of services that are subject to cost sharing.

Response: We have revised § 457.525(b)(1) to require that States also provide the public schedule at the time of a re-enrollment after a redetermination of eligibility. In addition, we note that § 457.525(a)(1) requires that the public schedule of cost-sharing requirements include information on current cost-sharing charges and the cumulative cost-sharing maximums. This information should specify the services or general category of services for which cost sharing is imposed and services that are exempt from cost sharing.

7. General Cost-Sharing Protection for Lower Income Children (§ 457.530)

At § 457.530, we proposed to implement section 2103(e)(1)(B) of the Act, which specifies that the State plan may only vary premiums, deductibles, coinsurance, and other cost-sharing charges based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income. We noted that this statutory provision and the implementing regulations apply to all cost sharing imposed on children regardless of family income.

Comment: One commenter requested that when considering the requirement that States not vary cost sharing based on the family income of the targeted low-income children in a manner that favors children from families with higher income over children from families with lower income, HCFA should consider the issue of disposable income. The commenter recommended that we should consider only the income the family receives above 100 percent of the FPL (disposable income). When applying a flat percentage assessment, the assessment will consume more of the lower-income family's disposable income than the disposable income of a higher-income family. The commenter cited the following example: A straight 3 percent assessment would consume 9 percent of the disposable income for a family at 150 percent of poverty but only 6.5 percent of the income for a family at 185 percent of poverty.

Response: We recognize that health care costs may consume a larger proportion of a lower income family's disposable income. Accordingly, at § 457.560(d), we provide for a lower cumulative cost-sharing maximum (2.5 percent) for cost sharing imposed on children in families at or below 150 percent of the FPL in part because of the higher proportionate consumption of disposable income at lower poverty levels. Also, in accordance with § 457.540(b), and section 2103(a)(1)(B) of the Act, copayments, coinsurance, deductibles and similar charges imposed on children whose family income is at or below 100 percent of the FPL may not be more than what is permitted under the Medicaid rules at § 447.52 of this part and the charges may not be greater for children in lower income families than for children in higher income families.

8. Cost-Sharing Protection to Ensure Enrollment of American Indians/Alaska Natives (§ 457.535)

Section 2102(b)(3)(D) of the Act requires the State plan to include a description of the procedures used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act). To ensure the provision of health care to children from AI/AN families, we proposed that States must exclude AI/AN children from the imposition of premiums, deductibles, coinsurance, copayments or any other cost-sharing charges. For the purposes of this section, we proposed to use the definition of Indians referred to in section 2102(b)(3)(D) of the Act, which defines Alaska Natives and American Indians as Indians defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). We also specified in the regulation that the State must only grant this exception to AI/AN members of Federally recognized tribes (as determined by the Bureau of Indian Affairs).

Comment: Several commenters requested that HCFA reconsider the AI/AN exemption. Many commenters noted that it is administratively burdensome (especially in States with small AI/AN populations) and expensive in light of the fact that a number of States have already negotiated contracts with health care entities that assume cost sharing for this population and application of the 10 percent limit on administrative expenditures. Many commenters recommended that we focus on technical assistance instead to assure that States are consulting with tribes. Some commenters were concerned that having no cost sharing for this group, but having it for other children in the program would single out AI/AN children in health care provider offices and facilities. Also, commenters believed our policy contradicts the statutory intent to prevent discrimination against children with lower family incomes. In their view, the elimination of cost sharing in these situations creates a different standard for a specific population group and may imply to both providers and families SCHIP enrollees that AI/AN children's parents cannot be relied upon to pay anything toward the costs of their health care. One commenter observed that if HCFA's reason for exemption is because AI/AN children are typically unable to pay cost sharing, then the exemption should apply to special needs children as well.

Response: Section 2102(b)(3)(D) of the Act requires that a State ensure the provision of child health assistance to targeted low-income children in the State who are Indians. In accordance with this statutory provision and to enhance access to child health assistance, we have specified that States may not impose cost sharing on this population. This exemption is consistent with section 2103(e)(1)(B) of the Act because this statutory provision prohibits States from imposing cost sharing based on the family income of targeted low-income children in a manner that favors children from families with higher income over children from families with lower income. The exemption from cost sharing for AI/AN children is not a variation of the cost sharing based on the family's income and is not a violation of section 2103(e)(1)(B). The cost-sharing exemption for AI/AN children is based upon the statutory requirement at section 2102(b)(3)(D), which requires particular attention to this population.

This cost-sharing exemption also reflects the unique Federal trust with and responsibility toward AI/ANs. The statute specifically singles out children who are AI/ANs and requires that States ensure that such children have access to care under SCHIP. The statute confirms that AI/AN children are a particularly vulnerable population, and that a requirement to pay cost sharing will act as a barrier to access to care for this population. Therefore, in order to operate a SCHIP program in compliance with section 2103(b)(3)(D), the only way to ensure access to AI/AN children is to exempt them from the cost-sharing requirements. In addition, absent this exemption for AI/AN children, these children may pursue services from the Indian Health Service (IHS) (where cost sharing is not required) without pursuing coverage under SCHIP or Medicaid. We disagree with the commenter's assertion that a similar exemption should be granted for children with special needs, there is no parallel statutory provision that requires States ensure access to this population. While the unique medical needs of this population are not insignificant, the AI/AN exemption is based on the Federal tribal relationship and responsibility for protection of this specific group. However, we do not believe there is sufficient rationale or authority for including special needs children under this exemption.

We further recognize that it may be administratively burdensome for some States to exempt this population if States are required to verify the status of

the enrollee as Indians. However, States may rely on the beneficiary to self-identify their membership in a Federally-recognized tribe and self-identification would substantially reduce the administrative burden and associated costs to the State. Also, this exemption will not single out AI/AN children at providers' offices and facilities if the State requires the enrollee to self-identify at the time of enrollment and the State provides inconspicuous identification for these children so that providers know not to charge them cost sharing at the time the enrollee receives services.

Comment: One commenter asked HCFA to clarify that cost-sharing charges are not imposed by Tribal clinics or community health centers.

Response: Under § 457.535, the AI/AN population is exempt from cost sharing. IHS facilities and tribal facilities operating with funding under P.L. 93-638 ("tribal 638 facilities") do not charge cost sharing to the AI/AN population.

Comment: Several commenters recommended that the States' costs incurred due to the AI/AN exemption should be reimbursed with 100 percent Federal funds.

Response: A State will be able to claim match for increased costs resulting from the AI/AN exemption at the State's enhanced matching rate. However, we do not have authority under title XXI to provide 100 percent FMAP for these costs and would therefore need a legislative change to do so.

Comment: Several commenters recommended that AI/AN enrollees be permitted to self-certify their AI/AN status if HCFA does not concur with the commenter's request to remove the AI/AN cost-sharing exemption.

Response: We agree and take note that we have revised the policy set forth in the preamble to the proposed rule. States may allow self-identification for the purposes of the AI/AN cost-sharing exemption. Self-identification is consistent with our policies that encourage States to simplify the application and enrollment processes.

Comment: One commenter suggested that we apply the AI/AN cost-sharing exemption to all Indians based on the definition referred to in section 2102(b)(3)(D). The commenter requested that we remove the provision in the proposed regulation at § 457.535 that would narrow this definition to "AI/AN members of a Federally recognized tribe." The commenter stated that this definition of AI/AN children is more restrictive than that in the Indian Health Care Improvement Act, has no basis in

title XXI and it is also inconsistent with the definition of Indian set forth in the consultation provisions at § 457.125(a), which expressly request that States consult with "Federal recognized tribes and other Indian tribes and organizations in the State * * *". The commenter indicated the view that there is little point in consulting with non-Federally recognized tribes about enrollment in SCHIP if the children of those tribes are not excluded from the premiums and cost sharing.

Response: Because the Federal/tribal relationship is focused only on AI/ANs who are members of Federally recognized tribes, this final rule only requires States to exempt from cost sharing AI/ANs who are members of Federally recognized tribes. With regard to the consultation requirements at proposed § 457.125(a), we note that, although the cost-sharing exemption is required only for AI/ANs who are members of a Federally recognized tribe, individuals from other tribes may be eligible for child health assistance under SCHIP. There are numerous issues other than cost sharing that are involved in designing and operating a program, and we believe that States should be open to consultation with all interested parties, including non-federally recognized tribes. As such, we have removed the consultation requirement from § 457.125 and encourage the participation of these groups in the public involvement process established by the State in accordance with the new § 457.120(c). Finally, we have modified the definition of American Indian/Alaska Native at § 457.10 to be consistent with the Indian Health Care Improvement Act, yet also comport more closely with the definition used in the Indian Self Determination Act (ISDEAA).

Comment: One commenter suggested that HCFA allow time for States to comply with this new requirement and not delay approval of State plans or plan amendments for the time it will take to change State law to implement this change.

Response: In a letter dated October 6, 1999, HCFA informed SCHIP State health officials that we interpret the SCHIP statute to preclude cost sharing on AI/AN children. Since October 1999, we have required States submitting State plan amendments to alter cost sharing to comply with the exemption in order to gain approval for these amendments. States that have not submitted such amendments have been given ample notice of this policy. We will expect all States to comply with the requirements of § 457.565(b), which implements the exemption of AI/AN targeted low-income children from cost

sharing and comply immediately with this requirement upon the effective date of this regulation.

Comment: One commenter suggested that States with small AI/AN Indian populations be waived from the cost sharing exemption so they can continue their programs as implemented.

Response: We realize there is some concern about the administrative difficulties related to exempting AI/AN children from cost sharing in States with small AI/AN populations. However, as noted above, we will permit AI/AN applicants to self-identify at the time of enrollment for the purposes of the cost-sharing exemption. This policy minimizes the administrative burden on States.

Comment: Two commenters asked HCFA to clarify that, in States with SCHIP or Medicaid expansions involving AI/AN adults or entire families, the cost-sharing exemption be applied to AI/AN adults as well.

Response: In States with separate child health programs or Medicaid expansions that provide coverage to AI/AN adults or entire AI/AN families, the cost-sharing exemption only applies to children. If a State has imposed a premium on the family, the State must reduce the premium proportionately so that it applies to adults only. They also must not deny children access to coverage if the adults in the family cannot make premium payments. We are not restricting cost sharing for AI/AN adults because section 2102(b)(3)(D) directly refers to children only.

9. Cost-Sharing Charges for Children in Families at or Below 150 Percent of the Federal Poverty Line (FPL) (§ 457.540)

Section 2103(e)(3) of the Act sets forth the limitations on premiums and other cost-sharing charges for children in families with incomes at or below 150 percent of the FPL. Pursuant to section 2103(e)(3)(A)(I) of the Act, we proposed that in the case of a targeted low-income child whose family income is at or below 150 percent of the FPL, the State plan may not impose any enrollment fee, premium, or similar charge that exceeds the charges permitted under the Medicaid regulations at § 447.52, which implement section 1916(b)(1) the Act. Section 447.52 specifies the maximum monthly charges in the form of enrollment fees, premiums, and similar charges, for Medicaid eligible families.

Section 2103(e)(3)(A)(ii) provides that copayments, coinsurance or similar charges imposed on children in families with income at or below 150 percent of the FPL must be nominal, as determined consistent with regulations referred to in section 1916(a)(3) of the Act, with

such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The Medicaid regulations that set forth these nominal amounts are found at § 447.54. For children whose family income is at or below 100 percent of the FPL, we proposed that any copayments, coinsurance, deductibles or similar charges be equal to or less than the amounts permitted under the Medicaid regulations at § 447.54. For children whose family income is at 101 percent to 150 percent of the FPL, we proposed adjusted nominal amounts for copayments, coinsurance, and deductibles to reflect the SCHIP enrollees ability to pay somewhat higher cost sharing. We proposed that the frequency of cost sharing meet the requirements set forth in proposed § 457.550.

We also proposed that the cost sharing imposed on children in families with incomes at or below 150 percent of the FPL be limited to a cumulative maximum consistent with proposed § 457.560. Specifically, we proposed that total cost sharing imposed on children in this population be limited to 2.5 percent of a family's income for a year (or 12 month eligibility period).

Comment: One commenter questioned if the cost-sharing limits at §§ 457.540, 457.545, 457.550, 457.555 and 457.560 apply to out-of-network cost-sharing charges. The commenter recommended that the limits only apply to services delivered through the network participating providers. If not, the commenter argued that States cannot effectively use managed care to control costs and will be unable to develop effective partnerships with employer-sponsored health insurance programs to provide SCHIP services.

Response: If an enrollee receives services outside of the network that were not approved or authorized by the managed care entity (MCE) to be received outside of the network, then the services are considered non-covered services and the enrollee may be responsible for related cost-sharing charges imposed (other than in the case of emergency services provided under § 457.555(d)) irrespective of the limits established under the above referenced sections. If, however, the services are authorized by the MCE and provided by an out-of-network provider, the cost-sharing limits of this subpart apply. A State must ensure enrollees access to services covered under the State plan, but a State has discretion over whether to use a fee-for-service or a managed care arrangement.

Comment: A couple of commenters observed that the premium limits as set

forth in the Medicaid regulations at § 447.52 are unreasonably low, since these cost-sharing provisions and limits have not been updated since the 1970s. These commenters proposed that we use a percentage (of payment) to set these amounts instead of a flat dollar amount.

Response: Section 2103(e)(3)(A)(I) provides that States may not impose enrollment fees, premiums or similar charges that exceed the maximum monthly charges permitted, consistent with the standards established to carry out section 1916(b)(1) of the Act. Permitting States to charge higher premiums on families with incomes at this level of poverty would be inconsistent with the statute.

Comment: One commenter suggested that the rule and preamble explicitly address the cost sharing treatment of children in families below the Federal Poverty Level. They noted that, in States that have retained the resource test for children in Medicaid, significant numbers of children below poverty will be enrolled in separate child health programs due to excess assets. This commenter recommended that § 457.540 be revised to reflect the fact that some adolescents under 100 percent of the FPL may be receiving SCHIP services until they are fully phased into regular Medicaid and that protections must apply to these children as well.

Response: Section 457.540(b) of the proposed regulation addresses the need for lower cost-sharing limits for cost sharing imposed on all children below 100 percent of the FPL. This section limits cost sharing to the uninflated Medicaid cost-sharing limits permitted under § 447.54 of this chapter. Section 2103(e)(3)(A)(I) limits premiums, enrollment fees, or similar charges to the maximums permitted in accordance with section 1916(b)(1) of the Act. In addition, because the definition of "child" includes adolescents under the age of 19, there is no need to revise this section. We have retained this proposed provision in the final regulation. However, it should be noted that we have added paragraphs (d) and (e) to § 457.540. These requirements were originally part of § 457.550, which has been removed to improve the format of the regulation.

Comment: One commenter disagreed with the separate grouping, relative to cost sharing, for SCHIP enrollees under 100 percent of the FPL and the application of the Medicaid cost-sharing limits to this population. The commenter noted that the proposal is beyond the statute (the statute only refers to two tiers—above 150 percent of the FPL and at or below 150 percent of the FPL) and that the monetary

difference between the SCHIP schedule applicable to 101 percent to 150 percent of the FPL and the Medicaid cost-sharing schedule is minimal. The commenter noted that the cost to States to create a program for this new income level is very significant. The commenter argued that the Medicaid cost-sharing requirements proposed for SCHIP enrollees under 100 percent FPL were developed two decades ago and have no connection to current health care costs or program changes. According to this commenter, creating this new tier of eligible SCHIP enrollees does not seem to comport with the flexibility provided States in the Congressional debate on SCHIP, or written in title XXI.

Response: Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose "a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with the regulations referred to in section 1916(a)(3) of the Act), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable." The Secretary has the discretion to determine the increases to the Medicaid cost-sharing limitations that are reasonable and under this authority the Secretary has determined that it is not reasonable for States to impose cost sharing above the Medicaid limitations contained in § 447.54 for children with family incomes that are below the Federal poverty line. As noted in the comment above, children at this income level who are eligible for separate child health programs typically reside in States that have retained the resource test for children in Medicaid, and may be well below 100 percent of the FPL. In this case, even small increments in cost sharing may impact the ability to access services.

10. Cost Sharing for Children in Families Above 150 Percent of the FPL (§ 457.545)

Section 2103(e)(3)(B) mandates that the total annual aggregate cost sharing with respect to all targeted low-income children in a family with income above 150 percent of the FPL not exceed 5 percent of the family's income for the year involved. The proposed regulation provided that the plan may not impose total premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges in excess of 5 percent of a family's income for a year (or 12 month eligibility period). We have deleted this section because it repeats the requirements already stated in § 457.560(c). Please see the comments and responses at § 457.560(c) for further discussion.

11. Restriction on the Frequency of Cost-Sharing Charges on Targeted Low-Income Children in Families at or Below 150 Percent of the FPL (§ 457.550)

Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, "with such appropriate adjustments for inflation or other reasons as the Secretary determines to be reasonable". We proposed to adopt the Medicaid rule at § 447.53(c) that does not permit the plan to impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service. We also proposed that a State may not impose more than one cost-sharing charge for multiple services provided during a single office visit.

We also proposed to adopt the Medicaid rules at § 447.55 regarding standard copayments. Specifically, we proposed to provide that States can establish a standard copayment amount for low-income children from families with incomes from 101–150 percent FPL for any service. We proposed to expand upon the Medicaid rules and allow States to provide a standard copayment amount for any visit. Similar to the provisions at § 447.55 that allow a standard copayment to be based upon the average or typical payment of the service, our proposed provision would allow a State to impose a standard copayment per visit for non-institutional services based upon the average cost of a visit up to the copayment limits specified at proposed § 457.555(a), on these families.

Comment: A few commenters asked if States can still charge an enrollment fee. HCFA should clarify that States can charge both an enrollment fee for SCHIP and copayments for services, provided aggregate and individual dollar limits on cost sharing are observed.

Response: States can charge an enrollment fee for families at or below 150 percent FPL as long as the enrollment fee does not exceed the maximums specified in § 457.540(a) for children in families at or below 150 percent of the FPL and does not exceed the cumulative cost-sharing maximum in accordance with § 457.560(d) (2.5 percent of a family's income for a year or length of the child's eligibility period). For enrollment fees imposed on children in families with income above 150 percent of the FPL, enrollment fees and other cost sharing are limited to the cumulative cost-sharing maximum specified in § 457.560(c) (5 percent of

the enrollee's family income for a year or the length of the child's period of eligibility). The restriction on imposition of one type of cost sharing in this section applies only to copayments, deductibles, and coinsurance or similar charges.

Comment: One commenter strongly supported the provision of the proposed rule that prohibits imposition of more than one copayment for multiple services provided during a single office visit. The commenter noted that this is a key issue for adolescents and that adolescents seek a variety of health care services on their own and seek to do so on a confidential basis (for example, diagnosis and treatment for a sexually transmitted disease). The commenter recommended that the preamble (or regulation) clarify whether there can be only one copayment required for a single office visit (for example, a \$5.00 copayment for the visit) and whether the copayment must cover any associated lab tests, diagnostic procedures, and prescription drugs, or whether any additional copayments can be required. The commenter urged that HCFA make clear that only one copayment per visit may be required for all services associated with the single visit.

One commenter opposed the prohibition on imposing more than one cost-sharing charge for multiple services provided during a single office visit. In the commenter's view, cost sharing should relate to the provision of services rather than a visit. The commenter noted that CPT IV codes for physicians do not bundle multiple physicians or multiple services into a single visit. In this commenter's view, the proposed rule is also more restrictive than the current Medicaid provisions, which tie cost sharing to services, not to visits. The commenter argued that this added restraint on cost sharing is unnecessary because SCHIP enrollees are already protected from excessive charges by the overall cost-sharing caps and the limits on copayments.

Response: Section 457.550(b) (now § 457.540(e)) specifies that States cannot impose more than one copayment for multiple services furnished during one office visit. Thus, the copayment must cover any associated lab tests and diagnostic procedures. Only one copayment per visit may be required for all services delivered during the single visit. Lab tests performed at another site or prescription drugs obtained at a pharmacy may be subject to additional copayments. While the commenter notes that this is more restrictive than Medicaid, under Medicaid a provider cannot deny services to an enrollee if he

or she cannot pay the associated copayment. SCHIP providers can deny services to enrollees under these circumstances. The per visit cost-sharing limit is intended to prevent access problems for SCHIP enrollees.

Comment: Several commenters requested that § 457.550(b) not apply to dental services or vision services because they are benefits that are defined by each individual service. In these commenters' view, limiting the frequency of cost sharing jeopardizes the State's ability to contract with many participating dental providers and limits the provision of needed dental services for SCHIP enrollees.

Response: The majority of State child health programs offer coverage for dental services and we believe this provision will not adversely affect State coverage of these services. In addition, provider participation is more likely to be influenced by States' payment rates than by cost sharing from enrollees. Once again, we believe it is important that the cost sharing on enrollees at or below 150 percent of the FPL be nominal in order to encourage enrollees to access vision and dental services before more expensive treatment is required.

Comment: One commenter indicated that § 447.550(b) should state that "any copayment that the State imposes under a fee for service system may not exceed \$5.00 per visit, regardless of the number of services furnished during one visit." Because the commenter assumes that the provider will seek the highest allowable copayment, for clarity, the rule should simply state that \$5.00 is the maximum allowable per copayment visit. Section 457.550(b) is redesignated as § 457.540(e).

Response: We have modified the regulation to clarify that the provider can only collect up to the maximum amount allowed by the State based on the total cost of services delivered during the office visit. The provider cannot charge copayments in excess of what the State permits under the State plan.

Comment: One commenter pointed out an error in paragraph (c) of § 457.550, which refers to the maximum copayment amounts specified in paragraphs (b) and (c) of this section. The reference should be to § 457.555 (b) and (c).

Response: We agree with the commenter and have made these corrections to the final regulation text (§ 457.550(c) has been redesignated as § 457.555(e)). In addition, we have revised the reference to include subsection (a) as well.

12. Maximum allowable cost-sharing charges on targeted low-income children between 101 and 150 percent of the FPL (§ 457.555).

Section 2103(e)(3)(A)(ii) of the Act specifies that for children in families with incomes below 150 percent of the FPL, the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, "with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable". We proposed provisions regarding maximum allowable cost-sharing charges on targeted low-income children at 101 to 150 percent of the FPL that mirror the provisions of §§ 447.53 and 447.54 but are adjusted to permit higher amounts.

Specifically, for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent we proposed the following service payment and copayment maximum amounts for charges imposed under a fee-for-service system:

Total cost of services provided during a visit	Maximum amount chargeable to enrollee
\$15.00 or less	\$1.00
\$15.01 to \$40	2.00
\$40.01 to \$80	3.00
\$80.01 or more	5.00

We proposed to set a maximum per visit copayment amount of \$5.00 for enrollees enrolled in managed care organizations. In addition, we proposed to set a maximum on deductibles of \$3.00 per month per family for each period of SCHIP eligibility. We noted that, if a State imposes a deductible for a time period other than a month, the maximum deductible for that time period is the product of the number of months in the time period by \$3.00. For example, the maximum deductible that a State may impose on a family for a three-month period is \$9.00.

We also proposed, for the purpose of maximums on copayments and coinsurance, that the maximum copayment or coinsurance rate relates to the payment made to the provider, regardless of whether the payment source is the State or an entity under contract with the State.

With regard to institutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL, we

proposed to use the standards set forth in the Medicaid regulations at § 447.54(c). Accordingly, we proposed to require that for targeted low-income children whose family income is at or below 150 percent of the FPL, the State plan must provide that the maximum deductible, coinsurance or copayment charge for each institutional admission does not exceed 50 percent of the payment made for the first day of care in the institution.

We proposed to allow States to impose a charge for non-emergency use of the emergency room up to twice the nominal charge for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL. In § 457.555(d), we further proposed that States must assure that enrollees will not be held liable for additional costs, beyond the specified copayment amount, associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network.

We realized that the regulation text as proposed regarding the limit on cost sharing related to emergency services was not clear. Therefore, we have added to § 457.555(a) that the cost-sharing maximums provided in this section apply to non-institutional services provided to treat an emergency medical condition as well. We also clarified in paragraph (c) that any cost sharing the State imposes for services provided by an institution to treat an emergency medical condition may not exceed \$5.00. We also removed proposed paragraph (d), because this requirement is already included in § 457.515(f).

Comment: One commenter suggested that copayments and deductibles for families with incomes over 150 percent of the FPL be subject to the same limits that apply for families with incomes 101 to 150 percent of the FPL, noted in § 457.555 (a) and (b).

Response: The limitations proposed in § 457.555 (a) and (b) implement section 2103(e)(3)(A)(ii) of the Act. This section of the Act only applies to cost sharing imposed on targeted low-income children in families at or below 150 percent of the FPL. With respect to targeted low-income children in families above 150 percent of the FPL, the statute explicitly sets forth different cost-sharing provisions at 2103(e)(3)(B) and permits States to impose cost sharing that is only subject to the 5 percent cumulative cost-sharing maximum. Therefore, we do not have the statutory authority to apply these limits to cost sharing on children in families with incomes above 150 percent of the FPL.

Comment: One commenter encouraged HCFA to make the maximum allowable cost-sharing charges consistent with Medicaid. The commenter noted that a family with an income at or below 150 percent of the FPL enrolled in SCHIP has the same disposable income as a family with an income at or below 150 percent of the FPL in Medicaid, and therefore should not be expected to absorb a higher cost-sharing limit. Also, in this commenter's view, because the family may move from one program to another, there should be consistency in cost sharing.

Another commenter stated that the cost-sharing limits in this section should have been based on the Medicaid maximums increased by the actual inflation experienced since the promulgation of the original Medicaid regulations.

Response: Section 2103(e)(3)(ii) of the Act limits the copayments, deductibles, or similar charges imposed under SCHIP, for families with incomes at or below 150 percent of the FPL, to Medicaid cost-sharing amounts "with such appropriate adjustments for inflation or other reasons as the Secretary determines to be reasonable." The cost-sharing amounts under Medicaid (found at 42 CFR 447.52) were originally established in regulation in 1976 and have never been adjusted for inflation. Therefore, using the discretion permitted under the statute, we inflated the schedule for SCHIP for cost sharing imposed on enrollees whose income is from 101 to 150 percent of the FPL. In doing so, we looked at both the general inflation rate and the level of need in the population at issue in reference to Medicaid recipients. Because children in families with incomes below the poverty line are more closely tied to the traditional Medicaid population, we have not inflated the Medicaid cost sharing limits found at § 447.52 for SCHIP enrollees with incomes at or below 100 percent of the FPL. We also note that under Medicaid, States cannot impose copayments, deductibles, and coinsurance on children under the age of 18. Therefore, children under the age of 18 who become eligible for the Medicaid program should not be subject to any copayments, deductibles or similar charges in accordance with § 447.53 of the Medicaid regulations. The SCHIP statute, however, clearly contemplates and permits the application of cost-sharing to SCHIP enrollees.

Comment: One commenter supported the higher cost sharing for non-emergency use of the emergency room. The commenter believes in promoting the concept of the medical home and

encouraging families to receive their children's care in that context.

Response: We appreciate the support of the commenter and also note that the policy, by only permitting twice the usual copayment amount for non-emergency use of the emergency room, protects the lower income populations served by SCHIP from having to pay excessive cost sharing if they find they can only access services at an emergency room. At the same time, it encourages enrollees to receive non-emergency services outside of an emergency room setting.

We realized that the proposed regulation text was not clear regarding the limit on cost sharing related to emergency services. Therefore, we added to section § 457.555(a) that the maximums provided in this section apply to non-institutional services provided to treat an emergency medical condition as well. We also clarified in paragraph (c) that any cost sharing the State imposes on services provided by an institution to treat an emergency medical condition may not exceed \$5.00. Finally, we removed paragraph (d) from this section, because the requirement is already included in § 457.515(f).

Comment: Several commenters were concerned about the language in § 457.995(c)(2) which prohibits patients from being held responsible for any additional costs, beyond the copayment amount specified in the State plan, that are associated with emergency services provided by a facility that is not a participating provider in the enrollee's managed care network.

Response: With respect to the issue of additional costs for out-of-network emergency services, we believe that any costs associated with evaluating and stabilizing a patient in an out-of-network facility in a manner consistent with the cost-sharing restrictions in this regulation at § 457.555(d) must be worked out between the State and the managed care entity. Given the nature of the circumstances that may necessitate emergency services, enrollees may not be able to choose their place of care. Thus, the regulations do not allow additional cost sharing to be imposed on the beneficiary for emergency services including those provided out-of-network as described in § 457.515(f)(1) of this final regulation.

Comment: Two commenters asked that we clarify the interpretation of the phrase at § 457.555 (a)(3) and (b) "directly or through a contract", with regard to payment made by the State. This commenter interpreted the phrase to mean that when the State operates SCHIP through employer-sponsored

health plans, States would be expected to determine the rates paid by those health plans to hospitals and other providers and apply the standards cited in this section to determine allowable cost-sharing limits. The commenter asserted that, if this is HCFA's expectation, these requirements will make it difficult for States to implement SCHIP programs utilizing employer-sponsored health insurance since the State is not the purchaser of health care services in these cases and does not have a legal basis for accessing confidential or proprietary information, such as rates paid by plans to participating providers. The commenter recommended that States that use employer-sponsored insurance be exempt from the requirements proposed of § 457.555 (a)(3) and (b) since these requirements are likely to dissuade many employers from participating in SCHIP.

Response: Any State that contracts with another entity to provide health insurance coverage under the SCHIP program is paying for services through a contract. If a State subsidizes SCHIP coverage other than through a contract, such as in a premium assistance program, the State is still responsible for ensuring that cost-sharing charges to enrollees in such plans comply with this regulation. We recognize that this might require some additional steps but it is important to provide these protections to all SCHIP enrollees uniformly. States, as part of any contract with a health insurer, should request the payment rate information to assure that cost sharing being imposed by the insurer does not exceed the amounts in this section. We are also revising § 457.555(b) to specify that copayments for institutional services cannot exceed 50 percent of the payment the State would have made under the Medicaid fee-for-service system for the service on the first day of institutional care. As previously discussed, employer-sponsored insurance is subject to the same cost-sharing limits as all separate child health programs. This rule applies to both managed care and premium assistance programs.

Comment: One commenter urged HCFA to include language in the preamble to underscore that the philosophy and structure of managed care delivery systems make unnecessary the use of cost sharing to control utilization. HCFA should encourage States to set lower maximum allowable cost-sharing amounts for institutional services.

Response: States have discretion under 2103(e) to impose cost sharing up to the limits established in the statute

and in this regulation. We note that many studies have shown that cost sharing does impact utilization in managed care delivery systems. We also note that 50 percent of the cost of the first day of care in an institution may be expensive for families below 150 percent of the FPL. We encourage States to set reasonable limits that take into consideration the income level of these families.

Comment: One commenter supported limiting copayments per inpatient hospital admission, but noted that the current proposal is based on each institutional admission. In this commenter's view, this policy has the potential to promote early release and frequent readmissions that could be detrimental to a child's health. The commenter suggested that cost sharing for institutional admissions be based on a period of time or some other criteria in order to prevent potential inappropriate releases.

Response: Section 2103(e)(3)(A)(ii) limits the imposition of cost sharing to the nominal amounts consistent with regulations referred to in section 1916(a)(3) of the Act. Proposed § 457.555(b) mirrors § 447.54 of the Medicaid regulations regarding institutional services with some clarification for its application in the SCHIP context. We have not found data that supports a pattern of early discharge exists in the Medicaid program due to this provision. Therefore, we will adopt the regulation as proposed, consistent with section 2103(e)(3)(A)(ii) of the Act.

Comment: One commenter indicated that, with regard to institutional services, the proposed regulation states that the cost sharing cannot exceed 50 percent of the payment the State makes directly or through contract for the first day of care in that institution. The commenter stated that, in a managed care context, the State does not pay a per day amount to the managed care entity (MCE). The commenter requested that HCFA clarify how this institutional cost-sharing limitation is to be interpreted in the MCE setting.

Response: We have clarified § 457.555(b) to indicate that cost sharing may not exceed 50 percent of the payment the State would have made under the Medicaid fee-for-service system for the first day of care in that institution. We believe this remains consistent with the legislative intent to keep cost sharing at nominal levels in accordance with Medicaid.

Comment: One commenter observed that the imposition of copayments for emergency room visits that mirror copayments for other services, including

physician or clinic visits (\$5.00 copayment) provides a negative incentive. States should have the ability to impose a differential copayment for emergency visits, even if it is minimally higher than that imposed for visits to a primary health care provider.

A commenter stated that, in order to control non-emergency utilization of the emergency room and to smooth the transition of families from SCHIP to commercial insurance coverage, States should be permitted flexibility in establishing the maximum copayment amount for such services and notes that, in some States, amounts up to \$25.00 have been permissible. One commenter noted that without differential copayments for emergency room visits, the incentives are aligned to promote use of a primary care model over unimpeded access to emergency rooms.

Response: We have revised § 457.555(a) of the final regulation to specifically require that services provided to an enrollee for treatment of an emergency medical condition shall be limited to the cost schedule under (a) of that section with its maximum of \$5.00. We also note that States are not required to charge the maximum amount permitted in § 457.555(a) for a physician service and may choose to impose a lower amount than \$5.00 on physician services, providing the incentive for the beneficiary to access services at the physician level before using the emergency room. In addition, § 457.555(c) permits a maximum amount of \$10.00 for nonemergency use of the emergency room, which may also create incentives to use the primary health care provider when appropriate.

For the targeted low-income child in a family with income above 150 percent of the FPL, States may impose a higher amount than \$5.00 for emergency services provided in an emergency room as long as the family has not paid cost sharing that exceeds the cumulative cost-sharing maximum of 5 percent of the family's income for a year. The regulation only requires that States limit copayments for emergency services provided in the emergency room to the schedule in § 457.555(a) for those children in families with income from 101 to 150 percent of the FPL, and limit such copayments consistent with § 457.540(b) for those children in families with incomes below 100 percent of the FPL.

Comment: A commenter recommended that no arbitrary amount (\$10.00) be used as the maximum copayment for non-emergency use of the emergency room. In this commenter's view, if such an amount is included in

this section, it should be indexed for inflation.

Response: The maximum copayment amount is based on the statutory requirement that cost sharing for families at or below 150 percent of the FPL must be in accordance with the Medicaid rules. The amount of \$10.00 in § 457.555(c) is consistent with § 447.54(b), which allows a waiver of the nominal amount in the Medicaid regulation for nonemergency services furnished in a hospital emergency room up to double the maximum copayment amounts. We have chosen a set limit for the SCHIP enrollees in families with income from 101 to 150 percent of the FPL in lieu of the complicated waiver requirement in Medicaid.

Comment: A commenter agreed that non-emergency use of emergency facilities should be limited. However, the commenter is concerned about doubling the noninstitutional copayment amount permitted when an enrollee uses an emergency room for non-emergency services. The commenter noted that, in many rural areas, access to non-emergency facilities may not be readily available, and argued that families should not be penalized (charged double) when alternative services are not available.

Response: Proposed § 457.735 (now § 457.495) of the regulation requires the State plan to include a description of the methods it uses for assuring the quality and appropriateness of care provided with respect to access to covered services. States must ensure that an adequate number of providers are available so families do not need to seek routine treatment in an emergency room.

Comment: Several commenters asked that the regulation clarify that States should use the prudent layperson standard proposed at § 457.402(b) in the assurance that cost sharing for emergency services to managed care enrollees would not differ based on whether the provider was in the managed care network.

Response: We agree that the prudent layperson standard should be applied to this section. In the proposed rule, we defined emergency services at § 457.402(c), to include the evaluation or stabilization of an emergency medical condition. Because this definition is relevant to the entire regulation, we have moved the definitions of emergency services and emergency medical condition to § 457.10. Section 457.10 now defines emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson,

with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in jeopardizing the individual's health (or in the case of pregnant women, the health of the woman or her unborn child), serious impairment of bodily function or serious dysfunction of any bodily organ or part.

Comment: One commenter suggested that HCFA issue additional guidance on what, if any, sanctions for non-payment of cost sharing can be exercised.

Response: States are allowed flexibility when proposing sanctions. HCFA will review the State sanctions as part of the State plan and consider proposed sanctions on a case-by-case basis. We will require that States, in accordance with § 457.570(b), provide an opportunity for the targeted low-income child's family to have its income reevaluated when the family cannot meet its cost-sharing obligations. The family income may have dropped to a point where the child qualifies for Medicaid, or where the child is in the category of SCHIP enrollees that is subject to lower (or no) cost sharing.

13. Cumulative Cost-Sharing Maximum (§ 457.560)

Section 2103(e)(3)(B) of the Act provides that any premiums, deductibles, cost sharing or similar charges imposed on targeted low-income children in families above 150 percent of the FPL may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing with respect to all targeted low-income children in a family may not exceed 5 percent of the family's income for the year involved. We refer to this cap on total cost sharing as the cumulative cost-sharing maximum.

We proposed two general rules regarding the cumulative cost-sharing maximums. First, a State may establish a lower cumulative cost-sharing maximum than those specified in § 457.560(c) and (d). Second, a State must count cost-sharing amounts that the family has a legal obligation to pay when computing whether a family has met the cumulative cost-sharing maximum. We proposed to define the term "legal obligation" in this context as liability to pay amounts a provider actually charges the family and any other amounts for which payment is required under applicable State law for covered services to eligible children, even if the family never pays those amounts.

We proposed that for children in families above 150 percent of the FPL, the plan may not impose premiums,

enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate exceed 5 percent of total family income for a year (or 12 month eligibility period).

We proposed that for targeted low-income children in families at or below 150 percent of the FPL, the plan may not impose premiums, deductibles, copayments, co-insurance, enrollment fees or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period.

Comment: A number of commenters disagreed with the proposed definition of "legal obligation" for use in connection with counting cost-sharing amounts against the cumulative cost-sharing maximum. They noted that it is very difficult and time-consuming to track payments that have not occurred. One commenter suggested changing the definition of the term "legal obligation" to only those "cost-sharing amounts, which families have actually paid."

Response: States may rely on documentation based upon provider bills that indicate the enrollee's share rather than relying only on evidence of payments made by the enrollee. We have not adopted the commenters' suggestion because this could result in families being legally obligated to pay cost-sharing amounts in excess of the cumulative maximum.

Comment: One commenter asked if this provision means that for any and all out-of-network health services, (provider charges in excess of the amount paid by the health plan) must count toward the family's cumulative cost-sharing maximum. The commenter noted that no private health plans work this way, especially employer-sponsored plans. According to this commenter, a requirement to recognize out-of-network provider charges would greatly complicate this process by requiring States to verify that provider bills submitted by families as evidence of having reached the maximum were not in fact paid by the health plan in which the children are enrolled.

Response: If an enrollee has been authorized by his or her health plan to receive out-of-network services, then the associated charges must comply with these rules and be counted toward the cumulative cost-sharing maximum. In addition, an enrollee's costs incurred for emergency services (as defined at § 457.10) furnished at an out-of-network provider also count toward the cumulative cost-sharing maximum. The regulation does not require coverage of out-of-network services that are not authorized, except for emergency

services. Therefore, States are not required to count costs of unauthorized services received out-of-network toward the cumulative cost-sharing maximum.

Comment: One commenter recommended that States be able to retain the flexibility to define the year for purposes of cost sharing as the insurance benefit year for group insurance rather than an individual family's eligibility period as proposed. In this commenter's view, the use of individual family eligibility periods would be an "administrative nightmare."

Response: States may apply the cumulative cost-sharing limits based on the insurance benefit's 12 month period for group insurance. In that case, for families that enroll during the benefit year, the State must calculate the cumulative cost-sharing maximum based on the income of the family only for the period of time the beneficiary is actually enrolled within that benefit year.

Comment: One commenter noted that these rules allow a State to count cost-sharing amounts that the family has a legal obligation to pay. The commenter indicated that as section 330 Public Health Service grantees, Federally qualified health care centers (FQHCs) are required to prepare a schedule of fees or payments for incomes at or below those set forth in the most recent FPL. They also noted that health centers are obligated to charge patients on a sliding scale basis if their income is between 100 and 200 percent of the FPL. Therefore, the commenter stated that, based on this proposed rule, health center patients will not receive cost-sharing credits for that portion of the copayments that the health center is expected to waive under a sliding fee schedule policy.

The commenter requested that HCFA provide an exception to consider SCHIP patients served in FQHCs as having paid the full highest possible copay cost of the copayment in calculating the cumulative cost-sharing maximum, whether or not they were charged this amount. In addition, the commenter indicated that SCHIP plans should be instructed that, if a FQHC normally charges its patients with incomes between 100 and 200 percent of the FPL on a sliding scale basis, it should not be required or expected to apply a cost-sharing charge to a SCHIP patient that would exceed its sliding scale discount. For example, if the health center charge for a service is \$100.00, but it only charges \$50.00 for those with incomes between 150 percent and 200 percent of the FPL, it should only charge 50 percent of the allowable copayment for

patients covered under SCHIP, in this commenter's view.

Response: States are only obligated to count towards the cumulative cost-sharing maximum the amounts that a patient has a legal obligation to pay. Therefore, States may not count the amounts that the health center covers towards the maximum. The State is only obligated to count what the SCHIP patient is actually charged by the health center for purposes of the cumulative cost-sharing maximum. However, we do agree that the FQHC should not charge the enrollee more than is permissible under the FQHC's sliding scale, nor should it charge the enrollee more than is permissible under the SCHIP program.

Comment: Several commenters requested that we reconsider the 2.5 percent cumulative cost-sharing maximum. They raised specific concerns regarding the 2.5 percent cumulative cost-sharing maximum, including: The provision is not supported by the statute; it is very difficult to administer two caps (2.5 percent and 5 percent) and track against two caps; limits on copayments and deductibles are already found in § 457.555 and section 2103(e)(3)(A) of the Act; States have already implemented flat cumulative cost-sharing maximums that are administratively efficient and provide families with fluctuating incomes greater stability; HCFA's commissioned study by George Washington clearly demonstrates that it is rare that enrollees will reach the 5 percent cost-sharing maximum; and when a limit is set using a percentage, there is no need to make the percentage less.

One of the commenters also noted that the Medicaid maximum charges for premiums and other cost-sharing charges, which apply to families at or below 150 percent of the FPL, are minimal in amount and are not based upon income or family size. As a result, the addition of another level of cost sharing (2.5 percent) adds to an already complex cost-sharing structure, in this commenter's view. The commenter added that such requirements are virtually impossible to implement in a program that subsidizes employer sponsored insurance.

Response: We disagree with the commenters. A lower cost-sharing maximum on children is necessary in order for States to comply with the requirements at section 2103(e)(2)(B), which require that separate child health plans may only vary cost sharing based on the family income of targeted low-income children in a manner that does not favor children in families with